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Experiences and Perceptions of Frequently Overlooked Groups in Mental Health Contexts

Griffith, Eleri

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**Experiences and Perceptions of Frequently Overlooked Groups in
Mental Health Contexts**

Eleri Griffith

North Wales Clinical Psychology Programme

Bangor University

June 2021

This thesis is submitted in partial fulfilment of the regulations for the
Doctorate in Clinical Psychology

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Declaration

I hereby declare that this thesis is the results of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.

Yr wyf drwy hyn yn datgan mai canlyniad fy ymchwil fy hun yw'r thesis hwn, ac eithrio lle nodir yn wahanol. Caiff ffynonellau eraill eu cydnabod gan droednodiadau yn rhoi cyfeiriadau eglur. Nid yw sylwedd y gwaith hwn wedi cael ei dderbyn o'r blaen ar gyfer unrhyw radd, ac nid yw'n cael ei gyflwyno ar yr un pryd mewn ymgeisiaeth am unrhyw radd oni bai ei fod, fel y cytunwyd gan y Brifysgol, am gymwysterau deuol cymeradwy.

E.Griffith

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Thesis Abstract

This thesis explored the experiences of two groups who are frequently overlooked within mental health contexts in the UK: bilingual Welsh-English clinical psychologists and young people who care for adults with an illness or disability.

The first paper, a thematic synthesis of qualitative studies focused on the experiences of young people with caring responsibilities for adults. The systematic search identified 22 peer-reviewed qualitative studies. A synthesis of identified papers' findings generated three analytic themes which captured the highly variable and dialectic aspects of young caring globally and across diverse caring contexts. Conclusions highlight the particularly adverse aspect of caring for others with certain conditions. The paucity of research on young caring in these contexts warrants further exploration. Recommendations are also made for greater collaboration across multi-disciplinary services to support the unmet needs and psychological health and wellbeing of this often invisible group.

The second paper reports on a qualitative empirical study of the experiences and perceptions of bilingual, Welsh first-language clinical psychologist practising in one health board in Wales. No previous study involving this group had been undertaken. Unstructured interviews were undertaken with nine participants and data gathered was analysed using Reflexive Thematic Analysis. Findings indicated that the experience of working as a bilingual Welsh-English clinical psychologist was valued, challenging and evolving. Recommendations are made regarding support for the professional and personal development of this minority group in the dimensions of clinical supervision, service leadership and development. These also have relevance for bilingual clinical psychologists in other global contexts.

The third and final paper considers the theoretical, research and clinical implications of the two research papers more broadly, their relevance and contributions to these three areas. Some of the lead-authors' personal reflections on the research process are also discussed.

Section 1 - Literature Review

Young-carers' experiences: a thematic synthesis of qualitative studies

Eleri Griffith, Dr Mike Jackson¹ and Dr Christopher Saville¹

¹North Wales Clinical Psychology Programme, School of Psychology, Bangor University, UK.

Corresponding Author: Eleri Griffith, North Wales Clinical Psychology Programme, School of Psychology, Bangor University, Bangor, Gwynedd. UK. Email: pep01a@bangor.ac.uk

This paper will be submitted to the Journal of Youth & Adolescence and as such will follow submission guidelines for the journal:

<https://www.springer.com/journal/10964/submission-guidelines>

Key words: informal carers, hidden carers, family, illness, thematic synthesis; meta-synthesis

Abstract

Objective

To synthesise qualitative studies exploring the experiences and perspectives of young-carers.

Design

Thematic synthesis of qualitative studies analysing direct accounts of care-giving.

Method

Systematic review of literature in accordance with inclusion and exclusion criteria and thematic synthesis involving line by line coding of participants' data in the form of direct quotes and study author(s) analysis and interpretation of findings.

Results

Twenty-two studies reporting the experiences of young-carers situated in several countries were included in the thematic synthesis. All studies bar two had mixed gender samples. Interviews were the predominant method of data-gathering with some using focus groups. Thematic synthesis identified three analytic themes: Multifaceted Variability; Constraining and Adverse; Contingently Constructive.

Conclusions

This thematic synthesis highlights how the multi-dimensional diversity of young-carers' experiences can be immensely challenging and dialectically beneficial. Their uniquely complex situations are highly contextualised and require greater collaboration across services. Certain contexts involving young-carers remain under-researched and warrant more research.

Introduction

The term young-carer has been used for over two decades to describe children and adolescents aged 18 years and under who provide substantial care for another person, usually a family member (Aldridge & Becker, 1993; Becker, 2007). Care-giving for many children, however, continues well into young adulthood, extending across key developmental stages. Hence the term young adult carers was coined more recently to describe young adult carers aged 18-25 (Becker & Becker, 2008). Research into young care-giving revealed that this could encompass domestic, nursing and personal care as well as emotional support which differed and substantially exceeded helping tasks typically carried out by peers (Warren, 2007).

Early research involving this hitherto ‘invisible’ group gave some indication of young-carers’ prevalence, although estimated numbers can vary significantly (Aldridge, 2018). Census data from 2011 (Office for National Statistics, 2013) stated that there were 166,000 children in England and Wales providing care for parents/other adults who had a chronic illness, injury or disability. However, a study by the BBC (2010) estimated that there were over 700,000 young-carers in the UK, where Wales has the highest proportion (Welsh Government, 2021). Studies in European, North American and African countries are also recognising the existence of young-carers as a hidden and vulnerable workforce, with an estimated prevalence of 2-8% in industrialised countries (Joseph et al., 2020).

A key factor in such discrepancies is the persistently hidden aspect of young-carers, which poses challenges for estimating prevalence, understanding the full extent of the caring they undertake and its impact (Joseph et al., 2020). Studies consistently highlight how young-carers remain invisible, despite policy and legislative efforts to identify and support them in places such as the UK (Aldridge, 2018). One factor influencing their relative invisibility is that many do not identify as young-carers with responsibilities beyond the norm but rather view their care-giving as helping out at home (Moore & McArthur, 2007). Perceiving their caring responsibilities as helping out has been found to be particularly common among young people within ethnic minority cultures and communities (Hill et al., 2011). However, prevalence of young-carers and reluctance to seek help from authorities

is higher among young people from ethnic minority backgrounds communities in the UK (Barnardo's, 2019).

Many young-carers and their families also fear the safeguarding consequences of disclosing their caring situations and maintain a veil of secrecy to prevent child protection interventions (Aldridge & Becker, 1993; Moore & McArthur, 2007). Reluctance to seek support is also driven by shame and can increase isolation (Butler & Astbury, 2005; Rössler, 2016). Stigma and shame have been identified as particularly salient among young-carers where care-recipients have mental health problems (Gray et al., 2008). Regardless of the reason, where young-carers are unacknowledged, they are potentially denied support and services that could help balance care-giving with social activities, continuing education and/or paid employment (Aldridge et al., 2016; Cass et al., 2009).

The impact of caring on young people places limitations on leisure pursuits, time with friends, educational attainment and has potential consequences for their health and wellbeing (Aldridge & Becker, 1993; Becker & Sempik, 2019). Difficulties with attendance and achievement at school hinder later progress in education, training and employment (Dearden & Becker, 2003). Limited engagement with school and peers can also impact on young-carers' psychosocial development (Aldridge et al., 2016; Thomas et al., 2003). Childhood and adolescence span key developmental stages and late adolescence in particular is conceptualized as a period of transitioning into adulthood where identity and world-views are explored and emergent (Arnett, 2000). Connecting with peers can help navigate sensitive and potentially difficult transitions; but young-carers are typically time-poor and often isolated, which can exacerbate these transitional stages (Erikson, 1968). Research has indicated that being or becoming a carer during key developmental stages such as adolescence can influence identity formation, leading to low self-esteem and increasing risks of interpersonal-relationship difficulties across their lifespan (Earley & Cushway, 2002; Jurkovic, 1997).

Young-carers can also experience difficulties with the transition from adolescence to adulthood by having prematurely adult-like caring responsibilities, tantamount to role-reversal which is often referred to in the literature as ‘parentification’ (Minuchin, 1967). A parentified child assumes responsibilities and undertakes caring tasks beyond what is considered developmentally and age-appropriate, to the detriment of their own emotional and developmental needs (Chase, 1999). Across diverse cultures, the likelihood of becoming young-carers and risk of parentification is particularly high if the care-burden is excessive, long-term and support from other family-members or services is inadequate (Becker, 2007). It has also been suggested that parentification can affect children’s attachment systems and relationships in adulthood, which can become dysfunctional because they find asking for help difficult, despite wanting care and support (Remtulla et al., 2012; West & Keller, 1991). Moreover, when young-carers develop a strong self-concept as carers, they can also become compulsive caregivers as adults and socialised into taking on unnecessary ‘caretaker’ roles within future relationships and familial roles (Charles et al., 2009; Valleau, et al., 1995). Even if they do not become ‘compulsive caretakers’, many can still experience difficulties in establishing and maintaining healthy relationships in adulthood (Aldridge & Becker, 1993).

The likelihood of young-carers experiencing emotional difficulties has also been highlighted and an estimated 45% have reported having mental health difficulties (Becker & Sempik, 2019). Factors such as disturbed sleep, lowered stress tolerance, loneliness, resentment, shame, anger and guilt can trigger and exacerbate anxiety and depression (Aldridge & Becker, 1993; Sempik & Becker, 2013). Many young-carers have also reported developing disordered eating and engaging in self-harm and substance misuse (Cree, 2003). The adverse impact of parental mental illness is well-established; and living with a family member who has an illness has been shown to increase the risk of mental health difficulties among children (Pakenham and Cox, 2014; Rutter & Quinton, 1984). With the added burden of care-giving, this vulnerability is heightened for young-carers (Aldridge, 2008). Literature on carers across age-groups has highlighted their increased vulnerability to developing mental health difficulties, especially if care-recipients also have a mental health problem (Petruccelli et al., 2019; Savage & Bailey, 2004; Shah et al., 2010).

Where young-carers have caring responsibilities for others with mental health and/or substance-misuse problems, the risk of developing their own mental health difficulties is even greater (Pakenham et al., 2006).

However, some positive aspects of young care-giving have also been found. Many young-carers perceive their care-giving as worthwhile, which can foster a sense of achievement, independence and competence (Becker, 1995; Aldridge & Becker, 1993). The capacity of some to cope with difficulties by applying strategies to reframe and appraise their situations more positively has been highlighted (Pakenham et al., 2006). Many young-carers have indicated that the practical skills they have learned can be generalised to other aspects of their lives and acquiring such life-skills can bring satisfaction and build confidence (Cassidy et al., 2014; Joseph et al., 2009). Some young-carers have also developed problem-solving and communication skills because of their interactions with adults, especially when seeking information or support (Skovdal et al., 2009). Such skills have been found to develop self-esteem and resilience which can buffer against psychopathology and enhance wellbeing (Ryff & Singer, 2003; Bisschop et al., 2004). Moreover, when social support is reciprocal, this can enhance self-efficacy and increase self-esteem, which can serve as protective factors against stress and the sequelae of common mental-health problems (Pakenham et al., 2007). For some young-carers, confronting illness and navigating hardships can bring an appreciation of positive aspects of their lives, encourage positive health behaviours, increase awareness of priorities and a focus on positive life-goals (Charles et al., 2010).

Since Aldridge and Becker's (1993) seminal study, which influenced UK policy and legislation, research into the prevalence and nature of young caring has grown across the globe (Joseph et al., 2020). Controversies and debates have also been sparked regarding conceptualisations of childhood; pathologising premature maturity and 'parentification'; and the merits and demerits of the 'moral crusade' regarding young-carers and how they should be supported (Aldridge, 2018). What is clear from well-established and emerging research worldwide, however, is that a substantial number of young-carers exist, undertake onerous tasks and face a myriad of challenges, regardless of their care-recipients' condition

(Aldridge, 2018). Furthermore, as countries become more aware of their existence, it is evident that young-caring is a global phenomenon. Although the extent to which health and social-care systems can provide support will be influenced by economic wealth and sophistication of care services, many aspects of being a young-carer appear to be universal (Joseph et al., 2020).

While there is a continually growing body of knowledge across continents regarding the prevalence and content of young care-giving, further research has been called for in order to gain a more in-depth understanding of young-carers' experiences (Aldridge, 2018; Joseph et al., 2020). Since Rose and Cohen's (2010) meta-synthesis over a decade ago, there have been several qualitative studies exploring the experiences of young caring in several countries. During that time, legislative and policy measures have been taken to support young-carers and improve their situations, such as the UK's Care Act (2014) and Social Services and Wellbeing (Wales) Act (2014) in devolved nations. However, the impact of the 2009 global recession has been widespread and in the UK austerity measures and poverty have disproportionately affected young-carers (Vizard et al., 2019). They remain easily overlooked yet in the midst of a global pandemic, the burden of care on young-carers has, unsurprisingly, increased substantially (Blake-Holmes, 2020). It was therefore deemed timely and appropriate to conduct a meta-synthesis of more recent qualitative studies exploring the experiences and perceptions of young-carers.

Method

Meta-syntheses

As a method of systematically reviewing qualitative research, meta-syntheses are increasingly used to provide an integrated understanding of a phenomenon by combining and synthesising knowledge from studies (Jensen & Allen, 1996; Lachal et al., 2019). While systematic reviews of quantitative studies and trials are well-established with clear and rigorous methods, reviews of qualitative studies are seen as more emergent and to an extent, more contentious (Barnett-Page & Thomas, 2009). Meta-synthesis is, essentially, an ‘umbrella’ term for a range of approaches used to synthesise findings from qualitative studies, the most common of which are meta-ethnography and thematic synthesis (Barnett-Page & Thomas, 2009). Many meta-syntheses utilise meta-ethnography, originally developed by Noblitt and Hare (1988) which has since evolved and been further developed (Sandelowski & Barroso, 2007). However, the approach to meta-synthesis selected for this review was thematic synthesis as outlined by Thomas and Harden (2008). Thematic synthesis provides a clear, systematic approach to synthesising qualitative studies in the same vein as meta-ethnography (Harden et al., 2018). However, it is deemed more suitable to a synthesis of several qualitative studies which may vary in methodological approaches and theoretical positions (Booth et al., 2016). An initial literature search by the lead-author indicated that studies involving young-carers adopted a variety of epistemological stances, theoretical frameworks and data-gathering methods.

Literature Search and Selection

The aim of this review was to gain an understanding of young-carers’ experiences of caring for others, usually an adult family member, by undertaking a thematic synthesis of qualitative studies. The review was conducted in accordance with PRISMA (Moher et al., 2009) guidelines for the conduct of systematic reviews and registered with Prospero (CRD42020218363).

Criteria for inclusion in the review were that studies:

- included direct accounts from young-carers of their experiences of providing care for an individual living with a mental or physical long-term illness/condition

- reported primary qualitative data including ethnographical, narrative, phenomenological, grounded theory and case studies using interviews or focus groups to gather data
- mixed method studies that included findings derived from qualitative data
- were written in English language
- were published in a peer-reviewed journal between January 2009 and December 2020 as a similar meta-synthesis by Rose and Cohen (2010) included studies published up to December 2008; and the aim of this meta-synthesis was to explore young-carers' experiences a decade later and following a global economic recession

Studies were excluded if they:

- solely included data from the perspectives of professionals or other adults
- integrated data from any adult(s) with data gathered from young-carers in the analysis

A literature search of the following databases was undertaken in December 2020: Web of Science; Pubmed; Cochrane Library and PsychINFO. Terms used for searches were: young, child* AND carer*, caregiver* AND parent*, famil*, relative*. The search strategy and terms were deliberately broad in order to yield the maximum possible number of qualitative studies and ensure relevant studies were not missed because of inadequate bibliographic indexing (Atkins et al., 2008). The search strategy also involved a manual search of a selection of studies' reference lists to check for any further relevant studies. This was undertaken by means of a backwards and forwards screening of articles cited, also known as citation chaining of references of included studies and citations using Google Scholar's 'cited by' function.

Data-extraction and Quality Assessment

Studies included in the review were re-read by the lead-author who completed a summary data extraction form (Appendix A) for each one, based on a template recommended by Noyes and Lewin (2011). In addition to completing a summary data extraction form for each study, data in the form of reported findings and supporting, verbatim text from participants' transcriptions were comprehensively extracted into individual documents. This enabled detailed analysis of each study in advance of synthesis and before

consolidation into one data-base in order to conduct the thematic synthesis procedure. Included studies were also assessed for quality using the ten-item list of criteria of the Critical Appraisal Skills Programme (CASP, 2018) framework for appraising the credibility and methodological rigour of qualitative research (Appendix B). Studies were assessed against each criterion as illustrated in Table 2 below. All studies were deemed to be of at least moderately high quality and therefore none were excluded for quality reasons. However, most studies failed to meet the criteria of explicitly demonstrating that the relationship between researcher(s) and participants had been adequately considered. More recent studies did address this to an extent, which possibly reflects the increasing emphasis on the critical importance of reflexivity in qualitative research (Finlay, 2002). There is some debate and contention surrounding the value of conducting quality assessment of qualitative studies as part of the process of meta-synthesis, largely due to variability of reporting comprehensiveness and diversity of approaches (Dixon-Woods et al., 2006). It is also important to note the degree of subjectivity involved in this quality assessment process, despite agreement between the lead-researcher and one of the co-authors. Nonetheless, the process proved worthwhile as no studies were assessed as poor quality, which further validated their inclusion.

Thematic Synthesis Procedure

Included studies were read in full several times by the lead author before commencing thematic synthesis, which involved systematically following the three-stage process as outlined by Thomas and Harden (2008): line by line coding of the data; developing descriptive themes; and generating analytic themes. Following familiarization with each study, the lead-author coded, line-by-line, the data for each study, which included participants' verbatim quotations and researcher interpretations. These 'free' codes were then grouped to develop descriptive themes, which effectively translated the concepts from one study to another to produce a combination of themes. These were then synthesised in an iterative, cyclical process to generate the more abstract but nonetheless representative analytic themes. Theme labels were discussed and reviewed with co-authors and revised accordingly before agreeing on the final, reported analytic themes.

Results

As illustrated in the PRISMA (Moher et al., 2009) flow-diagram below (Figure 1), searches identified 2735 studies after removing duplications, all titles of which were reviewed for relevance. The lead-author reviewed the abstract and title of every study retrieved against the inclusion criteria in order to identify studies for full reading. A stratified sample of these was also assessed by the co-authors with agreement reached on the 56 articles to be read in full by the lead-author. When these were assessed against inclusion criteria following full-reading, 34 articles were excluded, leaving 22 articles to be included in the review. Reasons for exclusion were tabulated and verified. In almost all cases, studies were excluded because they were quantitative; or analysis included data from adults, which was not evident from the abstract. Nine studies were excluded for one of the following reasons: theory development; solely sibling child-minding (2); sole focus on bereavement; retrospective; occupational choices; training needs-analysis; post-intervention study (2).

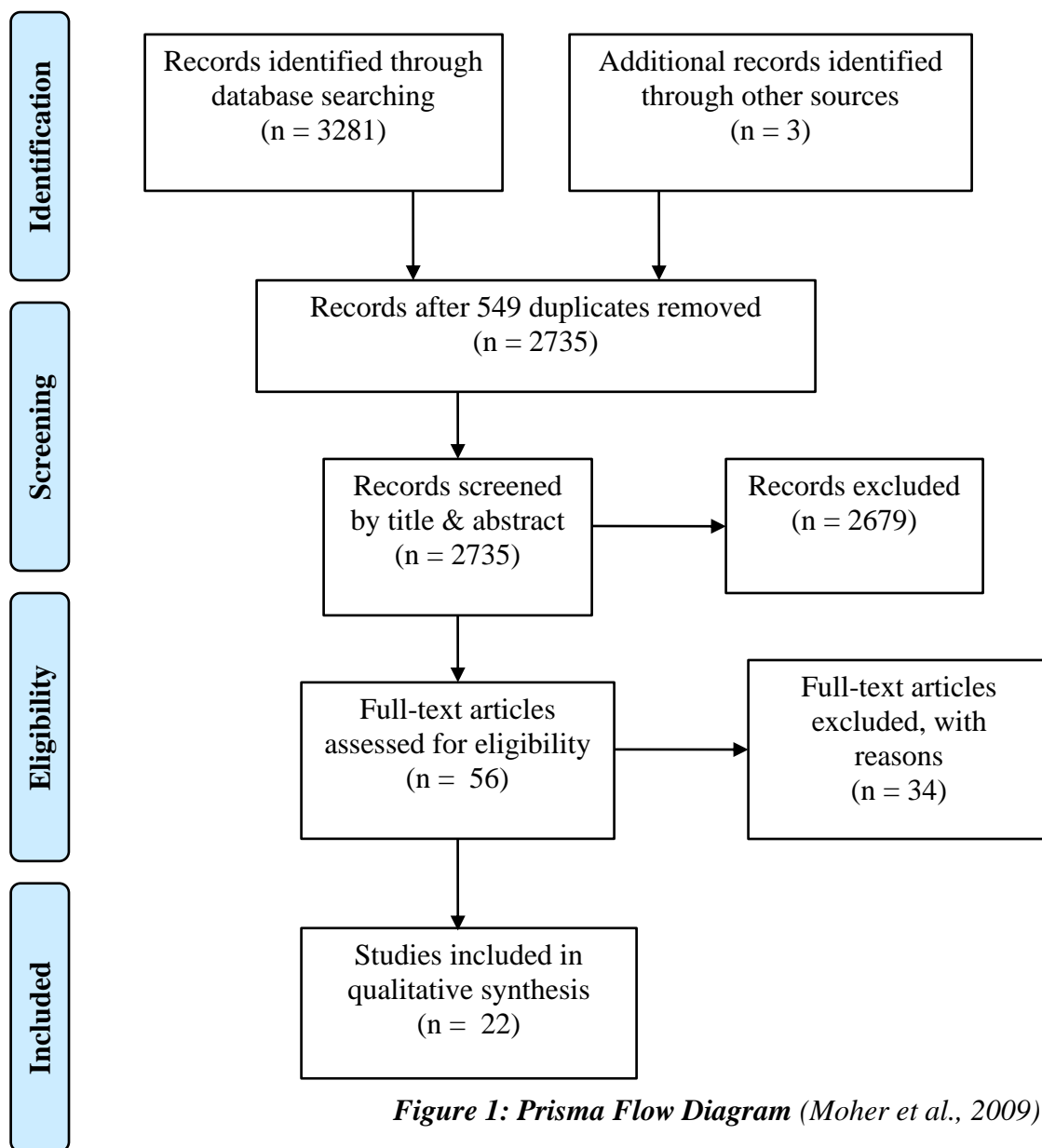


Figure 1: Prisma Flow Diagram (Moher et al., 2009)

Summary of Included Studies

As illustrated in Table 1 below, studies were situated across several countries and continents: Australia (6); UK (5); Scandinavia (4); North America (3); Europe (1); China (1); Africa (2). Apart from two studies, which had very small numbers, studies had mixed gender samples, although four did not specify gender split. Over half (15) included young adult carers (i.e. aged 18-25) with just one study having young adult carers only. Half of the studies focused on care-recipients with a specific index health condition while care-

recipients in other studies had a variety of illnesses and/or disabilities. In two instances, data sets from the same research studies were used twice by the same lead author, but with different research teams, aims and research questions. Interviews were the predominant method of data-gathering, though six studies used focus groups either solely or with interviews. A couple of studies creatively used drawings and images to facilitate data-gathering with their young participants. Only one study was longitudinal in design.

Table 1: Summary of Included Studies

Author and Country	Participants	Health Condition	Data-gathering and Analysis	Summary Findings
Moore et al. (2009) Australia	51 (29 F; 22 M) Age: 12-21	Mixed physical and mental health difficulties	Structured interviews; thematic analysis	Findings: school a respite; challenges of participating; harassment; lack of support; lack of understanding
Skovdal & Ogutu (2009) Kenya	3 (1F; 2F) Age: 13-15	HIV/AIDS	Semi-structured interviews, participatory photo-voice method; thematic analysis	Findings: meanings attached to circumstances influenced by social environment: positive, negative and mixed
Zhang et al. (2009) China	47 Age:8-17	HIV/AIDS; older adults with age-related conditions	Semi-structured interviews; grounded theory	Findings: caring for siblings and self; co-dependency of caring; fear; anxiety; personal growth and emotional maturity; suboptimal schooling
Svanberg et al. (2010) England	12 (6F; 6M) Age: 11-18	Dementia	Unstructured interviews; constant comparative method for interviews and analysis	Findings: discovering dementia; developing a new relationship; learning to live with it; going through it together
Barry (2011) Scotland	20 (10F; 10M) Age: 12-23	Mixed physical and mental health difficulties and alcohol misuse	Semi-structured interviews; thematic analysis	Findings: significance of social networks; reciprocity; stigma; friendship balancing act; school a refuge and challenge; mixed support; social network; emotional release of young-carer projects

Moore et al. (2011) Australia	15 (8F; 7M) Age: 11-17	Alcohol or other drug misuse	Semi-structured interviews using participatory design methodology; thematic analysis	Findings: levels of caring hard to quantify; care-giving varied; on high alert even in 'good' times; ambivalence of identifying as young-carer
Smyth et al. (2011a) Australia	68 Age: 11-25	Mixed physical and mental health difficulties	Structured focus groups; thematic analysis	Findings: identifying as carer through interaction with others; caring is familial obligation/responsibility; validation of young-carer identity; acknowledged; gaining support, explanatory label
Smyth et al. (2011b) Australia	68 Age: 11-25	Mixed physical and mental health difficulties	Structured focus groups; thematic analysis	Findings: varied caring trajectories; diversity of caring; physically laborious; giving emotional support; being different; balancing education; strong bonds; life-skills; protecting family's dignity
Ali et al. (2012) Sweden	12 (9F; 3M) Age: 16-25	Mental health difficulties	Semi-structured interviews plus focus group; descriptive content analysis	Findings: emotional impact; constant state of readiness; involuntary responsibility; unconditional support; taking action; managing strategically; self- protection; secrecy; attention seeking
Cluver et al. (2012) South Africa	659 Age: 10-20	AIDS and other illnesses	Structured interviews using participatory design methodology; thematic analysis	Findings: having to miss school; hungry at school; unable to concentrate; pride when achieving; school refuge and respite; peer support complex; stigma

Ali et al. (2013) Sweden	12 (9F; 3M) Age: 16-25	Mental health difficulties	Focus-groups and semi-structured interviews; inductive content analysis	Findings: striving for control; needing support; selective sharing; wary of overburdening; self-care; focus on positive; excluded by health professionals; lack of understanding; disclosure difficult
Hamilton & Adamson (2013) Australia	33 (19F; 14M) Age: 7-25	Mixed physical and mental health difficulties and alcohol/drug misuse	Semi-structured interviews; exploratory study; thematic analysis	Findings: varied pathways to care; impact of life-stage on aspirations; lack of understanding and support at school; caring prioritised; needing flexible employment; caring a vocation; constrained goals
Nichols et al. (2013) Canada	14 (10F; 4M) Age: 11-18	Dementia	Semi-structured interviews; thematic analysis	Findings: negative emotional impact; care-giving varied; developing coping strategies; dealing with diagnosis; changing relationships; variable support; disconnected from healthcare
Bjorgvinsdottir & Halldorsdottir (2014) Iceland	11 (6F; 5M) Age: 8-22	Multiple Sclerosis	Unstructured interviews; phenomenological study (Vancouver method)	Findings: uninformed; unsupported, unacknowledged; frightened; isolated; secret life; personal resources; embracing help; empowered by support; releasing negative feelings; gaining independence; valuable life-lessons; creating life-vision
Kavanaugh et al. (2015) USA	40 (31F; 9M) Age: 10-20	Huntington's disease	Semi-structured interviews; exploratory study; conventional content analysis	Findings: practical and emotional support needs; companionship; needing information/advice; understanding attitudes; peer support; caring for carers; treating family as 'normal'; developing patience; insufficient time to care properly

Leu et al. (2018) Switzerland	29 (24F; 5M) Age: 10-25	Mixed physical and mental health difficulties	Semi-structured interviews; grounded theory	Findings: caring wide ranging; intensity of caring; diverse entry and trajectories into care; difficult to communicate about carer role difficult; challenging interactions with family, peers and professionals
McDougall et al. (2018) Australia	13 (7F; 6M) Age: 14-25	Mixed physical and mental health difficulties	Semi-structured interviews; thematic analysis	Findings: learning from caring experience; benefits of caring; balancing competing demands; solace in solitude; social solidarity; the way it is; desire for normalcy; hiding carer role; lost in system
Stamatopoulos (2018) Canada	15 (12F; 3M) Age: 15-19	Mixed physical and mental health difficulties	Focus groups and interviews with survey follow-up (triangulation); thematic analysis	Findings: varied types and level of caring; carer penalty on work/employment, education and relationships; difficult, negative emotions; care rewarding
McGibbon et al. (2019) N. Ireland	22 (18F; 4M) Age: 8-17	Mixed physical and mental health difficulties	Semi-structured interviews; thematic analysis	Findings: complexity of caring; distress; loss; risk; difficulties supporting parental mental illness; excluded by health professionals; developing
Silvén-Hagström & Forinder (2019) Sweden	19 (8F; 11M) Age: 6-12 (at 1st interview)	Alcohol misuse	Longitudinal design: unstructured interviews at 3 time points; narrative analysis	Findings: two faces of alcohol-dependent parent; vulnerable victim; neglect and violence; competent agent; purposeful strategies; controlling/preventing alcohol intake; confronting; caring for many; disclosing 'family secret'; seeking help

Gough & Gulliford (2020) England	4 (4F) Age: 16-20	Mixed physical and mental health difficulties	Focus groups, open ended questions with topic guide; thematic coding approach	Findings: agency; benefit finding; social connectedness; building support networks; school positive and negative; making time for self; adjusting to care
Kettell (2020) England	3 (3F) Age: 20-23	Mixed physical and mental health difficulties	Semi-structured single interviews; interpretative phenomenological analysis (IPA)	Findings: split loyalties as carer and student; learning and studying challenging; overcoming hurdles; negotiating support

Table 2. CASP qualitative checklist for the thematic synthesis

Paper

CASP Checklist Questions

	Was there a clear statement of the aims of the research?	Is a qualitative method-ology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration ?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research
Moore et al. 2009	✓	✓	✓	✓	✓	X	✓	?	✓	✓
Skovdal & Ogutu (2009)	✓	✓	✓	✓	✓	✓	✓	?	✓	✓
Zhang et al. (2009)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Svanberg et al. (2010)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Barry (2011)	✓	✓	✓	✓	✓	?	✓	?	✓	✓
Moore et al. (2011)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Smyth et al. (2011a)	✓	✓	✓	✓	✓	?	✓	?	✓	✓
Smyth et al. (2011b)	✓	✓	✓	✓	✓	?	✓	?	✓	✓
Ali et al. (2012)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Cluver et al. (2012)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ali et al. (2013)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Hamilton & Adamson (2013)	✓	✓	✓	✓	✓	X	✓	?	✓	✓
Nichols et al. (2013)	✓	✓	✓	✓	✓	X	✓		✓	✓
Bjorgvinsdottir & Halldorsdottir (2014)	✓	✓	✓	✓	✓	?	✓	✓	✓	✓
Kavanaugh et al. (2015)	✓	✓	✓	✓	✓	?	✓	✓	✓	✓
Leu et al. (2018)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
McDougall et al. (2018)	✓	✓	✓	✓	✓	?	✓	✓	✓	✓
Stamatopoulos (2018)	✓	✓	✓	✓	✓	?	✓	✓	✓	✓
McGibbon et al. (2019)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Silvén-Hagström & Forinder (2019)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Gough & Gulliford (2020)	✓	✓	✓	✓	✓	?	✓	✓	✓	✓
Kettell 2020	✓	✓	✓	✓	✓	?	✓	✓	✓	✓

Key: (✓) assessed as possessing specified criteria (X) assessed as lacking specified criteria (?) not possible to assess sufficiently if possessing specified criteria

Synthesis of Findings

Thematic synthesis of included studies yielded three analytic themes:

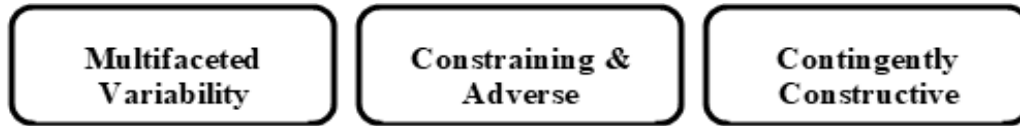


Figure 2: Map of Analytic Themes

Multifaceted Variability

This analytic theme captures the extent to which young-carers' experiences were highly variable and influenced by a myriad of contextual factors. Across and within studies, young-carers varied substantially in age; circumstances necessitating young caring responsibilities; duration, nature and extent of care-giving; and support from family and services. Furthermore, the experience of young-caring often varies over time for young-carers, not only as they grow older but also as care-recipient needs and family constellations change, often resulting in increased burden of care. The global spread of studies also highlighted how local and wider macro/socio-economic contexts also influenced how variable and multifaceted young-carers experiences can be.

The age and developmental stage at which they became young-carers and how they identified with the role were markedly different across and within studies. In some instances, participants became carers at a very young age and for many, caring extended well into their young-adult lives (Hamilton & Adamson, 2013; Kettell, 2020). For some who had been young-carers from an early age, caring seemed a natural and integral aspect of their lives as *“responsibilities of caring had formed a part of their frames for action for as long as they could remember”* (Hamilton & Adamson, 2013). For others, however, becoming a carer was an unexpected, sometimes sudden and often difficult life-change (Smyth et al., 2011a; Stamatopoulos, 2018). Identifying as a young-carer also differed across studies and caring contexts. Some participants felt the category was a label with strange, irrelevant and even negative connotations (Moore et al., 2011) while others embraced and integrated caring as part of their identity (Cluver et al., 2012). However, some did not identify as young-carers at all, either because they were unaware that their situations differed to that of their peers; or they considered care-giving as a filial duty or

‘helping out’ (Zhang et al., 2009; Svanberg et al., 2010; Smyth et al., 2011a). Whether or not participants acknowledged their status as carers, how far that was known and acknowledged beyond the immediate caring context also varied (Leu et al., 2018; McDougall et al., 2018).

The nature and extent of care-giving carried out by participants also differed substantially. Studies reported that young-carers often undertook multiple care-related tasks which ranged in intensity from routine domestic chores to administering medical treatments and intimate, personal care (Smyth et al., 2011b; Leu et al., 2018). Although several caring responsibilities were common to all participants, care-recipient’s illness dictated the extent to which young-carers had to carry out certain tasks such as heavy lifting or provide intensive emotional support (Kavanaugh et al., 2015). Care-recipient’s conditions, disease severity and extent of co-morbidity differed across and within studies, from physical health problems and/or disability to mental health difficulties, including cognitive impairment and/or substance-misuse problems. Whether care-needs were constant, intermittent or increased over time was also highly variable and influenced by multiple factors such as relapses, disease progression and/or the development of co-morbidity (Kavanaugh et al., 2015; McGibbon et al., 2019). For many participants, their age was a key factor in how *“caring responsibilities gradually increased as they grew older, by taking on more responsibility for tasks around the home or by providing increased levels of support to family members”* (Smyth et al., 2011b). While many participants cared for one person, often with no other adult in the home, some also cared for both well and unwell siblings, the other parent - and in some contexts, aging grandparents (Cluver et al 2012; Zhang et al., 2009).

Across all studies young-carers’ relationships and interactions with care-recipients and other family members varied widely. Some described having close relationships with care-recipients, while others expressed ambivalence and in some cases, even resentment (Smyth et al., 2011b). Although most participants were sole carers, some did share caring responsibilities with others in the home or received support from extended family members, while some received no familial support (Nichols et al., 2013). Even where

young-carers had familial support, this could vary over time as household compositions changed: “*M had always provided some care but this role intensified when her older sibling left home*” (Hamilton & Adamson, 2013).

Beyond immediate family constellations, participants experienced contrasting responses from adults and peers. Some received unsolicited support from their communities while others felt their care-recipients’ had been abandoned by friends and relatives (Kavanaugh et al., 2015; Skovdal & Ogutu, 2009). Similarly, within their own friendship groups, young-carers experienced diverse responses from friends, ranging from support to lack of understanding and in some cases disassociation (Ali et al., 2013). Levels of support influenced the varying reports given by young-carers regarding how well they were able to maintain social connections, engage in education and/or undertake paid work (Moore et al., 2009).

Experiences of the wider systems of education and healthcare and whether young-carers felt supported, acknowledged and informed by professionals were also variable (Kavanaugh et al., 2015; McGibbon et al., 2019). The extent to which countries had developed policies and systems to support young-carers differed markedly, even where economic wealth was not too dissimilar. Thus some, but not all, variability in how participants experienced services was influenced by their wider macro/socio-economic contexts. However, the impact of differing levels of poverty and access to health and social care across countries was understandably reflected in how variable the experience of young-carers can be across countries.

One notable difference between participants living in extreme poverty in sub-Saharan African and Western countries was how young-carers in the former become family income-generators at much younger ages (Cluver et al., 2012). As captured by Skovdal and Ogutu (2009) describing a 13-year-old participant, “*S has always played an important role in sustaining the household...he cultivates land with sorghum, some of which he sells to buy basic amenities or chicken or goats*”. Young-carers in studies situated in non-Western countries were also more likely to live in multi-generational homes where often

“grandparents and grandchildren provide reciprocal care” (Zhang et al., 2009). They also reported receiving community/extended family support to a greater extent than their Western peers, despite care-recipients’ having stigmatized conditions such as HIV (Cluver et al., 2012; Skovdal & Ogutu, 2009;). Despite the variability of young caring, however, many fundamental issues facing participants, in particular their adverse as well as constructive experiences were remarkably similar across studies and form the other two analytic categories.

Constraining and Adverse

This analytic theme relates to the inevitable restrictions that caring responsibilities bring to young-carers lives and the range of adverse experiences many endure as a consequence of providing care. Regardless of caring contexts, experiencing the constraining impact and adverse aspects of young caring was a theme throughout all reviewed studies to some degree as young-carers take on duties and responsibilities associated with adulthood rather than youth (Zhang et al., 2009). Becoming caregivers and the dissonance of role-reversal and ‘parentification’ was framed as something over which participants had no choice or power; yet it had a pervasive and all-encompassing effect on their childhood and adolescence (Barry, 2011; Svanberg et al., 2010). As highlighted by Stamatopoulos *“many participants noted how they ‘do not feel like teenagers’”*, citing a 17-year old participant: *“I’m like a parent now... although I know I’m too young to do that”* Stamatopoulos (2018). Age-inappropriate responsibilities inevitably meant constraints and opportunity-costs for young-carers who could not always attend school regularly or engage in leisure activities with peers (Kavanaugh et al., 2015; Stamatopoulos, 2018). Particularly salient for older participants was the impact of caring on employment and educational aspirations. Many felt that options for continuing/higher education further afield were untenable and finding flexible, carer-accommodating employment was challenging (Hamilton & Adamson, 2013).

Invariably restrictions due to caring led to social and self-perceptions of being different since it *“makes it kind of hard to relate to other people, I really struggle making friends”* (14-year-old participant)’ (McDougall et al., 2018). Feeling disadvantaged in this way can

affect young-carers' self-esteem, especially when they also experience lack of understanding and support from relatives, peers and service professionals (Smyth et al., 2011a; Bjorgvinsdottir & Halldorsdottir, 2014). Many participants "*believed that other people in their social network did not understand how it felt to care*" (Ali et al., 2012). Experiences of being excluded by peers because their ability to socialise was limited were widely reported (Barry, 2011; Nichols et al., 2013). Tensions in relationships with peers were also described by several participants for whom parentification and the role-reversal of young caring often permeated other relationships where their 'caretaking' attitudes towards peers could trigger resentment and tensions (Ali et al., 2013).

On a systemic level, many participants felt overlooked and unacknowledged by health professionals who focused solely on the care-recipient needs and/or were reluctant to include participants in care and treatment planning (Nichols et al., 2013; Bjorgvinsdottir & Halldorsdottir, 2014). While school provided a potential respite away from caring, many young-carers expressed disappointment at the lack of empathetic support and flexibility or adaptations with course/homework assignments offered by educators (Moore et al., 2009; Barry, 2011). Even young-carers who managed to progress to higher education felt their academic progress was hampered by caring responsibilities (Kettell, 2020).

Throughout studies, participants reported numerous negative emotional and psychological experiences and responses. Many experienced fatigue due to stressful and often physically demanding caring tasks, stating they "*felt both physically and psychologically tired.*" (Zhang et al., 2009). Fatigue was also attributed to insufficient sleep because of nocturnally attending to care-recipients' needs; and insomnia as a result of worries over safety (Silvén-Hagström & Forinder 2019). Lack of sleep affected cognitive processes such as concentration and learning, often exacerbated by worrying about care-recipients while at school/college (Skovdal & Ogutu, 2009). Disrupted sleep was also a factor in the high levels of stress and negative emotional states, such as low-mood and anxiety frequently described by participants (Bjorgvinsdottir & Halldorsdottir, 2014). Anxiety in particular was reported by several, due to multiple difficulties impacting upon their lives, from day-to-day domestic, financial and educational worries to uncertainty and fears that their care-

recipient would deteriorate further and/or die (Cluver et al., 2012; McGibbon et al., 2019). Many had experienced bereavement, anticipatory grief and the distress of witnessing relatives, especially grandparents, grieving their loss (Zhang et al., 2009).

Exacerbating their anxiety and low-mood were loneliness and isolation due to the lack of time young-carers have to connect socially (Hamilton & Adamson, 2013; Stamatopoulos, 2018). Many kept their caring-responsibilities hidden because of shame and stigma surrounding many care-recipients' conditions and/or fear of removal into care (Silvén-Hagström & Forinder 2019). Secrecy and shame compounded feeling isolated and alone as many participants felt ashamed of their homes and/or how illness was impacting on their care-recipients (Leu et al., 2018). Secrecy around caring was common to many caring contexts but featured more strongly where care-recipients had mental health and/or substance-misuse problems (Ali et al., 2012; Leu et al., 2018). As one six-year-old male participant poignantly revealed: "*I talk to the bird. She's a friend. I tell my secret to the bird. I only whisper it to her*" (Silvén-Hagström & Forinder 2019).

These young-carers were acutely aware of and sought to protect themselves and their care-recipients from the stigma of mental health difficulties; and judgemental attitudes and blame often directed towards people with substance-misuse problems (Silvén-Hagström & Forinder, 2019). Many also felt their shame and distress were compounded when their care-recipients had public 'breakouts' and outbursts of aggression (Moore et al., 2011). Young-carers of people with mental health and substance-misuse issues described living in a constant state of uncertainty and hyper-vigilance due to the unpredictability of their care-recipient's volatility, risky behaviours, and covert resourcefulness in accessing drugs and/or alcohol (Ali et al., 2012; Moore et al., 2011). Ironically, periods of stability, abstinence and remission were considered erratic and perceived as worse by many young-carers for whom recovery meant increased hyper-vigilance in anticipation of what they feared would be an inevitable relapse (Silvén-Hagström & Forinder, 2019).

More negative appraisals of care-recipients and difficult relationships with them and immediate family were reported by participants in contexts where care-recipients had

mental health and/or substance-misuse problems (Moore et al., 2011; Ali et al., 2012). The intense burden of providing emotional and psychological support when care-recipients have a mental health and/or substance-misuse problems, or develop co-morbid mental health difficulties, was a theme across studies. Many participants “*experienced much anxiety and depression in trying to help their parents manage their own sorrow and grief over having become chronically ill and dependent people*” (Bjorgvinsdottir & Halldorsdottir, 2014). Consequently, several young-carers also reported being concerned about their own psychological health or had already experienced mental health problems themselves and were acutely aware of their own vulnerability to depression and anxiety (Kavanaugh et al., 2015; McDougal et al., 2018). Moreover, these young-carers often reported receiving little or no emotional support from care-recipients; yet frequently reported having to provide higher levels of emotional support than those whose care-recipients had physical health conditions solely (Stamatopoulos, 2018).

In addition to emotional deprivation, studies involving care-recipients with substance-misuse and/or mental health problems also highlighted how their young-carers were also at risk of neglect and often experienced or witnessed violence and abuse (Silvén-Hagström & Forinder, 2019). Even when participants had not experienced violence, many were neglected and had unmet physiological and psychological needs, particularly when caring for people with substance-misuse problems (Moore et al., 2011). Often compounding their adverse experiences of neglect and unmet needs was how these young-carers often had to use strategies to restrict access to alcohol and/or drugs in order to keep themselves and their care-recipients safe (Silvén-Hagström & Forinder, 2019). Unsurprisingly, these young-carers did not report developing strengths and resilience which many have described, despite the challenges they face (McGibbon et al., 2019).

Contingently Constructive

This analytic theme reflects how, alongside the challenging and negative aspects of caregiving, for some participants this was a constructive experience albeit contingent on certain contextual factors. Participants across several studies reported experiencing positive affect and developing skills and strengths, such as resilience, which can buffer against stress and

adversities (Gough & Gulliford, 2020). A number of studies positioned young-carers as agentic and autonomous individuals who had developed coping strategies and life-skills as a result of providing care for themselves and others: *“many identified skills and dispositions that they acquired as a result of their caring responsibilities”* (Hamilton & Adamson, 2013). Developing practical skills necessary for running households and providing care were seen by many participants as useful, generalisable life-skills which made them more independent, enhanced their self-efficacy and consequently supported their wellbeing (Skovdal & Ogutu, 2009; Smyth et al., 2011b; McDougall et al., 2018).

Some also demonstrated self-awareness and creativity when practising self-care by finding ways to relax and take breaks, even when confined to the home, by resting, finding some solitude, reading, exercising or connecting online with others (Ali et al., 2013; McDougall et al., 2018). In order to manage the multiple demands of care-giving, keep care-recipients safe and balance caring with work, study or changing circumstances, many participants had developed problem-solving skills and became resourceful, proactive and adaptable (Bjorgvinsdottir & Halldorsdottir, 2014; Hamilton & Adamson, 2013; Kettell, 2020).

The ability to demonstrate psychological flexibility, resilience, grit and hardiness was also highlighted by a number of studies where participants had accepted, committed to and even embraced their challenging carer-responsibilities (Svanberg et al., 2010; Smyth et al., 2011b). Bjorgvinsdottir and Halldorsdottir (2014) highlighted how some participants *“consciously sought to establish personal stability in an effort to manage or control the more difficult or depressing episodes in their lives”*. Many applied the optimism, self-determination and ability to self-motivate they had developed to the ongoing challenges of caring while persevering with education and future career/vocational aspirations and goals (Hamilton & Adamson, 2013; Kettell, 2020). As Gough and Gulliford (2020) found, participants *“noted their inner strength and persistence to work towards achieving their goals and changing people’s perceptions about their abilities to cope...this suggest a determination to exercise some control and prove one’s self-worth, to negate others’ more negative perceptions of being a young carer”*. Their participants expressed an ability to appreciate positive aspects of their situations and focus on the here-and-now in order to

persist, even in the face of extreme difficulties (Gough & Gulliford, 2020). Other studies also highlighted that, although care-giving was something that they had no choice but to undertake, providing care was something many participants wished to do (Kavanaugh et al., 2015). A theme common to some studies was how young-carers valued their roles and were able to frame caring as a meaningful and important activity they were proud and pleased to provide for loved ones (Skovdal & Ogutu, 2009; Stamatopoulos 2018; McDougall, et al., 2018).

Many young-carers reported developing empathy and compassion because of care-giving and described having close, loving relationships and strong bonds with their care-recipients, which some felt were deeper as a result of time spent caring: *“strengthening family bonds and relationships was regarded as a positive outcome of caring”* (Smyth et al., 2011b). Where participants reported receiving reciprocal care, support and appreciation of their care-giving, this fostered positive affect and helped maintain healthy attachments (Barry, 2011). Such positive experiences of the caring relationship supported the development of interpersonal communication and relationship-building skills, which some young-carers were able to generalise to other life-domains (McDougall et al., 2018). Some studies highlighted how participants used the assertiveness, relational skills and self-efficacy they had developed as carers to navigate difficulties and negotiate with extended family, health and social-care services for practical, financial and emotional support (Leu et al., 2018; Nichols et al., 2013). Most participants in Bjorgvinsdottir and Halldorsdottir’s (2014) study *“believed the most valuable lesson learned was that of breaking the silence and learning to speak openly about their parent’s condition and their own caring responsibilities”*.

Several were also aware and valued how different friendship groups met their differing needs and actively sought the companionship they needed at different times (Moore et al., 2009). Many described the importance of being with others whose shared experiences meant they understood their situations in ways others did not (McDougall et al., 2018). Many enjoyed connecting with peers online and in person via young-carer projects/services, although these were not universally available, required being known to

services and often involved proactive information-seeking to access (McGibbon et al., 2019). Adults involved in young-carer projects were often a source of practical and emotional support which some found invaluable (McGibbon et al., 2019). However, at other times, being with non-caring peers meant some respite from carer responsibilities and opportunities to enjoy social contact where they could focus on other, non-caring aspects of childhood and youth (Stamatopoulos, 2018).

Some young-carers felt schools provided vital access to both other carers and non-caring peers and were therefore valued as a source of social interaction and connectedness with friends, which supported their wellbeing (Moore et al., 2009; Gough & Gulliford, 2020). While experiences of educational and health services were negative for many, a few found schools to be positive and enabling. Where young-carers were able to experience support, they described education professionals as highly supportive, respectful, compassionate and understanding (Barry, 2011; Cluver et al., 2012). Educators who not only demonstrated understanding and compassion but also supported young-carers to manage the substantial stress of academic pressures had a profound impact. In such instances, participants' experiences of education were positive and affirming and this, in turn, facilitated their academic progress, enhanced their self-efficacy and developed their resilience (Gough & Gulliford, 2020; Kettell, 2020).

The following table provides extracted samples of supporting data to illustrate the descriptive themes developed and the three analytic themes generated:

Table 2: Examples of Supporting Extracts and Descriptive Themes per Analytic Theme

Analytic Theme	Descriptive Theme	Extract from Study (participant quotes and author(s) interpretations)
<i>Multifaceted Variability</i>	Varied pathways into care-giving	Participants reported a diverse range of pathways into care based on a range of factors including the way that the condition of the care recipient had developed or progressed and the dynamics of household composition. (Hamilton & Adamson, 2013)
	Varying attitudes towards school	The role of school for young carers...was an ambivalent one: partly it can be a 'safe haven', away from the worries of the caring role, but some respondents suggested that they wanted to keep school separate from that caring role, almost so as not to 'contaminate' that safe haven. (Barry, 2011)
<i>Constraining & Adverse</i>	Uncertainty	<i>"I don't know what is happening in my life because when my mother is sick, I don't go to school. I have to look after her and my little brothers and sisters."</i> (Cluver et al., 2012)
	Shame and Secrecy	<i>"I never spoke about my family situation. They asked me "Can we come home to your place?" I never invited them home because I was ashamed of our household, because I was ashamed of my mother. I was so ashamed."</i> (Leu et al., 2017)
<i>Contingently Constructive</i>	Gratitude	<i>"You do have that 'oh my gosh I'm so lucky to have what I have'... I can walk properly or I'll be able to run and intellectually I can pursue what I want to."</i> (McDougall et al., 2018)
	Acceptance	<i>"I always thought it was just the way life was...so I kind of just accepted it"</i> (Smyth et al., 2011a)

Discussion

This aim of this thematic synthesis was to gain an understanding of young-carers' experiences from qualitative studies exploring this question over the past decade. Despite their diverse geographic and socio-economic contexts, studies were found to have a number of highly consistent themes. Thematic synthesis of these studies' findings resulted in three analytic themes, namely: *Multifaceted Variability*; *Constraining and Adverse*; and *Contingently Constructive*. These analytic themes encapsulate the experiences of young-caring as being highly diverse and dichotomous, reflecting to some extent findings from earlier research. However, more recent studies have highlighted aspects of young-carers' experiences in certain contexts which have not previously been extensively researched. Consequently, in reviewing what it means to be a young-carer, this thematic synthesis provides some insight into how the multi-dimensional diversity of their experiences can be both immensely challenging and difficult but also, sometimes, positive and beneficial.

The theme of 'Multifaceted Variability' was a thread throughout reviewed studies and captures the complex, nuanced and diverse experiences of participants across multiple dimensions of their care-giving. At individual levels, young-carers' experiences varied widely and across several dimensions of their lives, from age at entry into carer roles to duration, nature and extent of caring responsibilities. Even where contexts were similar, such as caring for others with the same or similar health conditions, experiences of young-carers can be highly variable. Beyond their immediate caring-contexts, young-carers experiences of interacting with and support from social and professional services; and engagement with education and employment also varied widely. While extant literature on young-carers has captured how varied the role of a young-carer can be, this review has underlined just how extensively multifaceted and variable these experiences are. Ensuring they are adequately supported is therefore complex and challenging, requiring an approach that is highly person-centred and which takes account of each young-carer's unique needs, circumstances and caring contexts. Ensuring timely and appropriate support is critical to mitigate long-term and adverse consequences of young caring (Becker, 2007).

The theme of ‘Constraining and Adverse’ captures the negative experiences and limiting consequences of young care-giving. Arguably, this has been the dominant narrative surrounding young-carers since the term was coined and research began almost three decades ago. Unfortunately, constraining and adverse consequences of young caring persists and is consistent across the more recent studies included in this review. Being a young-carer can limit the extent to which they can engage with education and lifestage-typical, age-appropriate activities, often resulting in isolation and loneliness which can compound stress associated with the burden of care. Persistent stress can result in the sequelae of disturbed sleep, low-mood and anxiety which were also negative consequences of being a young-career across reviewed studies. Psychological difficulties were reported by young-carers across all caring contexts; however adverse experiences of neglect and abuse were much more widely reported where care-recipients had mental-health or substance-misuse problems. Although conclusions regarding associations cannot be drawn from non-quantifiable findings, studies included in this review indicate that this particular subset of young-carers have increased exposure to adverse childhood experiences. This is of particular concern in light of the well-established developmental and psychological impact of adverse experiences on a young person’s trajectory into adulthood and their increased vulnerability to psychological and physical health problems (Petruccelli et al., 2019).

Despite the difficulties young-carers can face, for several the experience can be positive and for some, caring can foster personal growth, which underpins the theme of ‘Contingently Constructive’. However, as this review found, constructive experiences are highly contingent upon contextual factors, such as appropriate support at familial and social levels, care-recipients’ conditions and the burden of care. Earlier literature has indicated that many young-carers benefit from the positive experiences of care-giving including developing coping and skills, pride and independence. Studies in this review demonstrated how some young-carers also develop skills and strengths which extend beyond the development of practical life-skills and coping strategies, which can buffer against stressors and enable growth. This thematic synthesis therefore highlights how young-carers, when adequately supported, can develop psychological skills and build strengths

which enhance resilience when encountering adversities and the stress of care-giving. The development of psychological flexibility, relational and communication skills highlighted by this theme indicates the potential for personal growth among young-carers. Underpinning this growth is the development of self-efficacy, self-esteem and positive affect, which can enhance wellbeing and have been shown to be highly protective factors against stress and mental health difficulties (Bandura, 2004; Henriksen et al., 2017; Tugade & Fredrickson, 2004).

Relevance and Implications

Caring during childhood and adolescence can have a profound impact on psychological development, health and wellbeing; and consequences for trajectories into adulthood. The analytic themes identified from this thematic synthesis highlight how young-carers' experiences, while similar in many ways, are also dichotomous and highly variable over time. Given how unique each young-carer's experience is across some key developmental stages, service provision that is multidisciplinary, person-centred, responsive and adaptable to each individual need is critical. This can only be achieved if professionals across disciplines in health, social-care and education work collaboratively to ensure young-carers are supported; and that they are involved in their care-recipients' treatment and care planning. In particular, services providing treatment for people with mental health and substance-misuse problems need to actively take account of and include any young-carers in treatment planning and provision, possibly also engaging with colleagues in children's services.

It is hoped that a thematic synthesis of findings from studies included in this review can provide some useful insights for policy-makers, service managers and practitioners across disciplines and across the globe. While in the UK significant strides have been made through legislation and policies to ensure services support young-carers, the need for greater awareness and support provision remains. Regardless of geography, measures taken to mitigate the adverse impact of caring on young people can not only reduce risks of psychopathology and improve outcomes but also potentially result in growth. Supporting young-carers to recognise their skills and use their experiences to build strengths could

help buffer against the stress of caring in youth and adulthood. Such preventative early interventions are feasible and cost-effective to implement with some collaboration across services.

Limitations and Future Research

This thematic synthesis into the experiences of young-carers reviewed 22 peer-reviewed studies which were of at least moderately high quality and followed an established process to ensure a rigorous and systematic search and analysis. However, there are a number of limitations to this review. Firstly, although studies met an acceptable level of quality, there is a risk that more comprehensive studies may have had greater contributory impact on the synthesis of findings. Secondly, the sample is highly heterogeneous in a number of aspects beyond the wide geographical spread of studies. The diversity of care-recipients' health conditions in reviewed studies was also broad. Furthermore, some studies focus on specific conditions while in others, samples included a mix of care-recipient conditions. It is generally acknowledged that certain illnesses are seen as more stigmatised and blameworthy than others (Rössler, 2016). As acknowledged by some studies, care-recipients' health condition(s) can bring a different dimension to young-carers' experiences. Some studies also acknowledged their predominantly white participant samples, despite efforts to recruit young-carers from ethnic minority backgrounds.

Given the heterogeneity of studies in his review, future syntheses should perhaps focus on specific care-recipients conditions to provide more in-depth knowledge of young-carers' experiences in these particular contexts. Findings from this thematic synthesis indicated that experiences of caring for others with predominantly physical health conditions differed from contexts where care-recipient's index health condition was mental health or substance-misuse related. Focusing on a specific health condition giving rise to young caring could highlight in more detail issues pertaining to those contexts. Furthermore, research to date involving families where parents/adults have mental health and/or substance-misuse problems has mainly focused on the general impact on children in the home (Pakenham & Cox, 2014). The added dimension of being a young-carer brings a further element of burden and potential adverse childhood experiences in these contexts

(Aldridge, 2008). There is a dearth of research involving young-caring for people with mental health or substance-misuse, which future research should seek to address. Further research exploring the experiences of this particularly vulnerable group of young-carers in these contexts is needed before a synthesis of findings can be meaningfully undertaken. It is also notable that within the UK nations, no recent studies focusing on Welsh young-carers' experiences could be found since Thomas et al. (2003), even though Wales has the highest UK prevalence. Given the specific legislative and policy contexts of Welsh health and social-care and in particular the Welsh Government's commitment to children's wellbeing, this is a gap in research that needs to be addressed.

Conclusion

This thematic synthesis reviewed findings from 22 studies over the past decade, highlighting that, while the variability and challenging aspects of young-carers' experiences prevail, there can be positive aspects to young caring. Although contingent on factors such as adequate and appropriate support, being a young-carer can be constructive and lead to personal growth and the development of skills and strength that can enhance wellbeing and resilience. The need for person-centred care where young-carers can collaborate in the formulation of their needs over time and be included in care and treatment planning for their care-recipients could enhance the experiences of young caring and protect against the potential for adverse experiences and the sequelae of mental health difficulties for these young people. Further research on specific caring contexts for young-carers would also increase understanding and awareness on how services could best support this often invisible and overlooked group.

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Section 2 – Empirical Paper

Working as a bilingual, Welsh-speaking clinical psychologist: a qualitative study

Eleri Griffith, Dr Mike Jackson¹ and Dr Christopher Saville¹

¹North Wales Clinical Psychology Programme, School of Psychology, Bangor University, UK.

Corresponding Author: Eleri Griffith, North Wales Clinical Psychology Programme, School of Psychology, Bangor University, Bangor, Gwynedd. UK. Email: pep01a@bangor.ac.uk

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Key words: bilingual, clinical psychologist, Welsh language, psychological therapist

Abstract

Access to Welsh-medium psychological services in Wales is very limited and the number of bilingual Welsh-English clinical psychologists is low, even though both languages have official status. Research indicates that psychological assessment and interventions delivered in clients' preferred languages is optimal. Some studies have focused on bilingual psychotherapists but no research has been undertaken with bilingual clinical psychologists. The aim of this study was to begin to address this gap by exploring the experiences of Welsh-English bilingual clinical psychologists practicing in Wales. Unstructured individual interviews were conducted with nine participants working in one Welsh health board. Reflexive Thematic Analysis of data gathered produced three themes, two of which had sub-themes: Valued Resource; Navigating Challenges; and Shifting Paradigms. Findings highlighted the complex, nuanced and dialectical experiences of Welsh-speaking clinical psychologists who practise bilingually. Recommendations are made for service leadership and supervision to support this marginal and minority group of clinicians. Further research on bilingual, clinical psychology practice than this initial small-scale study is also needed.

Introduction

Worldwide there is an increasing focus on delivering linguistically sensitive and culturally competent mental health interventions (Ramos-Sánchez, 2009; Softas-Nall et al., 2015). Welsh is the native/heritage language of Wales, a country situated to the west of mainland Britain where English and Welsh have official status. Although part of the UK, Wales was once an independent country. Since the Welsh Government was established in the late 20th century, Wales now has some devolved powers. At one time, Welsh was spoken by most people in Wales but by the early 20th century it had become a minority language. Speaking Welsh was actively discouraged in schools which prioritised English as the language of educational achievement and professional progression (Davies, 2007). The number of Welsh-speakers continued to decline until the 21st century. According to the 2011 census 19% of the population in Wales spoke Welsh (Office for National Statistics [ONS], 2011). There are, however, marked regional variations as Welsh-speakers are typically concentrated to the north and west of the country, predominantly in its largely rural counties. Over 72% of the population speak Welsh in Gwynedd, a large county in north-west Wales; but further east and in the densely populated south this can be as low as 11% (ONS, 2011).

Most Welsh-speakers are bilingual Welsh-English from school age, although English fluency can vary and many consider themselves subordinate bilinguals (Gathercole & Thomas, 2009). Bilingualism is the ability to speak two languages with equal/near equal fluency; however, proficiency can vary substantially and most bilinguals learn languages in different contexts and not always simultaneously (Castaño et al., 2007). Many bilinguals are ‘subordinate’ rather than fluent or ‘equilingual’ (Matthews, 2014) especially if their first-language (L1) is spoken at home and routinely dominates daily-life and discourse (Sciarrà & Ponterotto, 1991). Languages are not totally interchangeable and some words and concepts are beyond translation: even fluent bilinguals cannot always provide an exact translation of their internal narrative (Panayiotou, 2004).

There is a legal requirement to offer bilingual Welsh-English services, but in certain areas such as healthcare this is not always possible due to difficulties recruiting Welsh-speakers (Thomas, 2005). However, the quality of mental healthcare can be compromised when it not undertaken in L1 (Bauer & Alegría, 2010). Mental health services offered in Wales are largely English-medium and this lack of access to Welsh-language services is problematic and disadvantages L1 Welsh-speakers (Madoc-Jones, 2004; Roberts et al., 2004). Many L1 Welsh people, although capable of speaking English to varying degrees, feel more comfortable discussing health-related difficulties in Welsh; and mutual language comprehension is clearly critical to delivering appropriate healthcare (Misell, 2000; Madoc-Jones, 2004; Roberts et al., 2007; Williams, 2003). Participants have reported feeling ‘unreal’ and detached during English-medium psychological therapy and that the lack of opportunity to speak Welsh hindered progress towards recovery (IAITH/WG, 2012).

There is a commitment to increasing access to Welsh-medium psychological services in Wales (WG, 2019) and Welsh clinical psychology programmes actively seek to recruit Welsh-speaking trainees. However, the number of Welsh-English bilingual clinical psychologists who can work through the medium of Welsh remains low and underrepresented, even in areas with high numbers of Welsh-speakers. To date, no research exploring the experiences and perceptions of bilingual Welsh-English clinical psychologists has been undertaken. This study aimed to explore the experiences of psychologists working bilingually as Welsh-speaking clinicians in the hope that it would yield some knowledge and insights that could inform services, training providers and practitioners.

Bilingualism and Psychological Practice in Clinical Contexts

Globally, research on bilingual clinical psychological practice is scant. There have been studies on bilingualism in the context of psychological therapy, predominantly focusing on Hispanic therapy clients¹ in the US. These typically involve surveys or small-scale, often

¹ Client will be used as a generic term for patients and service users as it reflects extant literature

single-case studies undertaken within psychotherapy and through the theoretical lens of psychoanalytic and cognitive psychology. There has been some limited research into the experiences of bilingual therapists/practitioners, again predominantly in North America. Such studies, however, include practitioners who do not necessarily share the same L1 as their clients; or monolingual practitioners working with bilingual clients (Bowker & Richards, 2004; Costa, 2010). Most studies on bilingualism in psychological therapeutic contexts thus focus on clients; but given that practitioners and clients are inextricably linked within the therapeutic relationship dyad, findings from these studies also have relevance for bilingual practitioners.

Typically, much of the research has been small-scale although a global survey involving nearly 200 international bi/multilingual participants, found that the majority highly valued the ability to express themselves in their language of choice during psychological therapy (Dewaele & Costa, 2013). Overall, the effectiveness of psychological therapy has been found to be associated with understanding as a result of language proficiency (Bradford & Muñoz, 1993; Burck, 2011; Hansen et al., 2000; Kissil et al., 2013; Musser-Granski & Carrillo, 1997; Peters et al., 2014; Torres et al., 2017; Van Loon et al., 2013; Woidneck et al., 2012). Where practitioners are able to work psychologically in clients' preferred language, this can facilitate emotional expression, reframing of cognitions, support the development of coping strategies and build resilience (Burck, 2011; Kirmayer, 2012; Van Loon et al., 2013; Woidneck et al., 2012). Furthermore, when a therapist can speak a client's L1 and has a shared cultural background, this can have a positive impact on the therapeutic relationship, process and outcomes (Ramos-Sánchez et al., 1999; Santiago-Rivera et al., 2009; Verdinelli & Biever, 2009). However, a shared language and culture can lead to over-identification and/or collusion between therapist and clients, who may also find such commonalities inhibiting (Altarriba & Santiago-Rivera, 1994; Dewaele & Costa, 2013; Nguyen, 2014). Such findings have profound implications for clinical psychological practice.

The language of cognitive and emotional processes for bilinguals is, however, complex. Amati-Mehler et al. (1993) purported that L1 is the medium by which speech patterns and

cognitive processes are initially developed; and bilinguals develop schemas according to the language used in differing contexts (Foster, 1996; Dewaele & Costa, 2013; Pavlenko, 2005). However, many posit that thoughts are formed in pre-linguistic ‘mentalese’, with language intervening at a later stage of pre-vocalisation, potentially in either language for bilinguals (Fodor, 1975; Grosjean & Li, 2013; Pinker, 2005; Pavlenko, 2011). Multiple factors can influence language choice in expressing inner thoughts such as proficiency, frequency of use, time and place of acquisition (Dewale, 2011). The language of emotions is also complex and shaped by each bilingual’s unique situation (Pavlenko, 2002, 2005).

In general, however, bilinguals prefer to communicate feelings and thoughts using L1 as this is typically the language of their inner dialogue (Pavlenko, 2005; Dewaele, 2008, 2015, 2016). Studies indicate that internal responses expressed in L1 are communicated more candidly and authentically; and clients feel less constrained by the cognitively-loaded process of searching for appropriate translated words (Burck, 2004; Byford, 2015; Softas-Nall et al., 2015; Torres et al., 2017). Where L1 is the language used most frequently, it is more likely to be the language in which bilinguals feel most comfortable describing emotionally difficult experiences (Biever et al., 2002; Burck, 2011; Collado et al., 2016). For many bilinguals, therefore, L1 is considered to be their language of ‘emotional expressiveness’ (Burck, 2004) while L2 is often associated with emotional distancing (Dewaele, 2004; Sutton et al., 2007). Costa (2010) purports that when bilinguals have experienced and encoded a trauma in L1, recalling and relating it in L2 serves as protection from traumatic memories. The use of a later-learned language has been described as a ‘distancing strategy’ to avoid painful events experienced in L1 (Dewaele, 2010; Pérez-Foster, 1998).

Language for bilinguals is thus seen as having a ‘dual function’ of protection against emotional pain; and enabling unfettered expression in order to facilitate therapeutic change (Kokaliari et al., 2013; Foster, 1996). Participants surveyed by Dewaele and Costa (2013) reported using language switching both to access *and* distance themselves from experiences, with some describing this capacity to manage their ‘emotional flow’ as highly empowering. Tehrani and Vaughan (2009) also concluded that language switching by

bilinguals provided an opportunity to develop ‘emotional mastery’, as problems explored in a different language can bring new perspectives. Imberti (2007) similarly concluded that language switching to find more appropriate words to express difficult emotions enhanced emotional self-regulation. Costa (2010) reported that bilingual therapists’ frequently used their bilingualism to support bilingual clients with finding appropriate words and/or phrases to capture their emotional experiencing and enhance understanding. Use of language switching by bilingual practitioners is viewed as a useful strategy which can enhance the therapeutic relationship and encourage client self-disclosure (Kapasi & Melluish, 2015).

Being able to work bilingually and language-switch is not only advantageous for psychological interventions; it is also highly salient for assessment and formulation where accurate understanding of explored emotions, cognitions and behaviours is critical. Numerous studies have highlighted that when psychological interventions are conducted in clients’ L2, the effort of focusing attention on translation can result in emotions being tempered or ignored, making accurate assessments of their needs difficult (Novy et al., 2001; Snowden & McClellan, 2013; Softas-Nall et al., 2015; Torres et al., 2017; Van Loon et al., 2013; Woidneck et al., 2012). Such findings are equally applicable when conducting assessments and collaborative formulations, as misinterpretations due to language comprehension by clinicians and clients can lead to misdiagnoses and a failure to provide culturally competent, ethical care (Liu, 2013; Novy et al., 2001; Torres et al., 2017; Verdinelli & Biever, 2013).

The reality in Wales and other countries, however, is that many clients have no choice but to use their L2 during psychological therapy. When this occurs, many have reported feeling detached from their thoughts, feelings and experiences, which can hinder therapeutic change (Softas-Nall et al., 2015; Torres et al., 2017). These experiences resonate with findings that even proficient bilinguals feel different when using their L2, with some reporting feeling more ‘fake’ or inauthentic when speaking languages other than L1 (Costa, 2014; Dewaele, 2016; Dewaele & Nakano, 2013; Ożańska-Ponikwia & Dewaele, 2012; Pavlenko, 2006). Focusing on finding correct language to describe thoughts, emotions and

behaviours in L2 can distract clients from the content of their experiences (Gutfreund, 1990; Ramos-Sánchez et al., 1999; Sciarra & Ponterotto, 1991; Torres et al., 2017). As well as potentially misrepresenting cognitions, when clients can only use L2 they may be denied the opportunity for emotional release, which could compound negative affect, thereby hampering progress and intervention effectiveness (Sciarra & Ponterotto, 1991). As Perez-Foster (1998) cautioned, “essential material” can be “lost in the cognitive traffic of bilingualism” (p.202) when psychological therapy is not conducted in the client’s L1.

However, even where therapists can speak a client’s L1, they have also reported discomfort and awareness of their lack of fluency and the impact this can have on psychological processes (Verdinelli & Biever, 2009). Practitioners have reported that ensuring accurate translation of theoretical terminology and concepts can be challenging and distracting during psychological therapy (Biever et al., 2002; Torres et al., 2017; Verdinelli & Biever, 2013). Even fluent bilingual practitioners have reported difficulty finding the appropriate translation for clinical terms or phrases learned in English (Verdinelli & Biever, 2013). Estrada et al. (2018) found that translating clinical terminology was difficult for most practitioners who expressed a wish for support to improve their use of non-English psychological terms. English has thus been found to be most psychological therapists’ preferred language for practice because it is the language in which they trained (Santiago-Rivera & Altarriba, 2002). Psychological therapy training in English-speaking countries has been described as Anglo-centric (Trimble, 2001) and criticised for failing to prepare practitioners for working with speakers of other, often heritage, languages (Fondacaro & Harder, 2014; Minas et al., 1994; Wright, 2014).

Extant literature would suggest that working psychologically in client’s preferred language is optimal but that practising as a bilingual clinical psychologist can be intricate and complex. As there has been no previous research exploring the experiences and perspectives of Welsh-speaking clinical psychologists who work bilingually, the hope was that this study could begin to address this gap in existing knowledge.

Method

The aim of this study was to explore and gain insights into how bilingual Welsh-English psychologists have experienced working and training as bilingual clinicians. This small-scale, exploratory study is therefore situated within an interpretive research paradigm and is qualitative and phenomenological in design. This research design is appropriate for capturing the rich, detailed descriptions required to understand the perceptions and experiences of bilingual Welsh-English clinical psychologists. This study adopted a contextualist position, a relativist/constructivist epistemological and ontological stance that knowledge is provisional and situation-dependent, influenced by historical, cultural and social contexts (Jaeger & Rosnow, 1988). This stance suggests that there is no single 'shared reality' (Ritchie & Lewis, 2003) as individuals' experiences and perceptions of a phenomenon and its meaning represents their subjective 'truth', shaped by their unique contexts (Krauss, 2005). Within this approach, the lead-author sought to capture how participants described, perceived and made sense of their subjective experiences (Langdridge, 2007) as bilingual clinicians practising within the context of mental health in Wales.

As the experiences and perspectives of bilingual, Welsh-English clinical psychologists had not hitherto been explored, the methodological approach selected for this experiential, phenomenologically-informed study was Reflexive Thematic Analysis (RTA; Braun & Clarke, 2013, 2020). Positioned at the qualitative, interpretative end of the spectrum of thematic analysis approaches, RTA offers an accessible, theoretically flexible, reflexive yet systematic and rigorous method of analysing qualitative data and identifying patterns of meaning across data-sets (Braun & Clarke, 2019, 2020). This makes it highly suitable for qualitative research exploring participants' experiences and perceptions of an under-researched phenomenon (Braun & Clarke, 2013, 2020; Morrow, 2007; Willig, 2013). Interpretative Phenomenological Analysis (IPA; Smith et al., 2009) was initially considered for this phenomenologically-informed research project as IPA also focuses on gaining in-depth understanding of individual experiencing and sense-making. However, RTA was deemed more appropriate, as in addition to enabling phenomenological exploration of subjective experiencing and sense-making, RTA also focuses on how these

individual, personal experiences are situated within wider socio-cultural contexts (Braun & Clarke, 2020). IPA with, its idiographic emphasis, also typically involves very small participant samples, often as few as three to six with just one being acceptable if data is sufficiently rich (Smith, 2004; Noon, 2018). As this exploratory study hoped to involve as many participants as possible, RTA offered much greater flexibility as it can be applied to very small or larger participant samples (Braun & Clarke, 2013, 2021)

Participants

Purposive sampling (Patton, 2002) ensured all participants had experience of the phenomenon of interest (Rappaport, 1987) and met the inclusion criteria of being Welsh-speaking clinical psychologists who practise bilingually. Participants were recruited across all services and geographical areas of one Welsh health board to protect their anonymity and increase the study's dependability. The pool of potential participants was identified using a database of Welsh-speaking clinical psychologists working in the health board. A total of 13 potential participants were sent a written invitation to participate in the study from the lead-author and provided with a bilingual Welsh and English participant information pack (Appendix C). Potential participants were asked to indicate their interest by replying directly to the lead-author. They were also invited to contact the lead-researcher should they wish to ask further questions prior to deciding whether to participate.

Of the potential pool of 13 participants, nine volunteers met the inclusion criteria of being Welsh-English bilingual, practising clinical psychologists. This sample size was deemed appropriate for this small-scale qualitative study seeking to gather rich, in-depth, detailed data. There has been considerable debate regarding adequate sample sizes in qualitative research with 'saturation', broadly the point at which data yields no new information or themes, widely held to be the critical indicator of validity (Constantinou et al., 2017; Guest et al. 2006, 2012). Many, however, have questioned the feasibility and logic of universally applying the concept of saturation, emanating from Grounded Theory (Glasser & Strauss, 1967) with its essential aim of achieving *theoretical* saturation, to all forms of qualitative inquiry (Low, 2019; Nelson, 2016). More applicable to RTA is a focus on *thematic*

saturation (Braun & Clarke, 2021) which studies suggests can be achieved at eight or nine individual interviews (Coenen et al., 2012; Namey et al. 2016). Interviewing nine participants met this recommended number of participants for RTA and it is notable that after seven interviews, no new themes were identified. Furthermore, the sample represented over two-thirds of the maximum possible participants who met the inclusion criteria within the geographical region where research permission had been granted.

Participants were of mixed gender; ranged in age, specialisms and service-length. Mean age was 46, ranging from 32 to 56 years. Average length of service was 19 years, ranging from 5 to 28 years). To preserve participant anonymity and confidentiality, no further biographical information will be provided. All participants were proficient Welsh-English speakers, able to work equally well and comfortably in English and Welsh. For the majority, Welsh had been the sole language of their home environment and education for all had either been Welsh-medium or bilingual Welsh-English up until higher education.

Procedures

Once ethical approval permissions had been obtained, potential participants were identified from a database of practising psychologists in the health board. An email invitation to participate included a participant information sheet (Appendix C) which explained the study's aim, the right to withdraw and that participation would be anonymous and voluntary. How data would be captured, stored and confidentially destroyed after the study's completion was also explained. Participants were assigned a gender-neutral P-number pseudonym and briefed prior to providing their signed, informed consent (Appendix D) and before data-gathering commenced.

Data-collection

Each participant attended a single individual interview as this method enabled them to share their experiences and what these have meant for them openly and freely without the inhibiting effect of group-interviews (Morgan, 1997). Interviews were unstructured so that participants could relate their experiences and perceptions in their own words and without constraint (Kvale, 1996; Mason, 2002). Each participant was asked only one question,

namely the research question for the study: “what have been your experiences of working as bilingual Welsh-English clinical psychologists? Due to the Covid-19 pandemic, interviews took place remotely by video-conferencing at a time to suit participants and were undertaken in Welsh. Each interview lasted a minimum of an hour with most lasting an average of 70-90 minutes. A short debrief at the end provided more context on the study’s purpose, an opportunity to discuss/ask any further questions and raise any concerns after reflecting on their experiences. With participants’ consent, each interview was recorded using a digital recorder and transcribed fully, excluding all possible identifiers.

Analysis

All transcripts and recordings were listened to and re-read by the lead author to check for accuracy and any omissions prior to analysis. Data was analysed in Welsh and supporting extracted data translated prior to writing the report in English. A sample of translated data-extracts was verified for accuracy by a Welsh-language teacher/translator. Data was analysed following Braun and Clarke’s (2006; 2019) procedures for conducting RTA. It is an iterative, six-step process with clear guidelines (Appendix E) for analysing qualitative data, beginning with in-depth immersion and data-familiarisation before generating initial codes and then searching for, checking and defining themes. Although TA is systematic and stepwise, it also requires researchers to cycle back and forth between stages in order to rigorously re-examine themes and ensure they reflect and capture the meaning of textual data.

The lead-researcher listened to and re-read interview transcripts several times to gain an overall sense of the data. Codes were annotated (Appendix F) clustered into categories and colour-coded according to initial themes. Themes were then re-evaluated and relabelled as necessary, with supporting translated text for each theme extracted from transcripts and translated. This systematic process was followed rigorously with the aim of presenting a credible and trustworthy analysis of the data (Guba & Lincoln, 1994). Member-checking can enhance trustworthiness and credibility of qualitative studies by minimizing the potential for bias as qualitative researchers typically collect and analyse the data which could lead to researcher-voice possibly dominating that of participants (Lincoln & Guba,

1985; Miles & Huberman, 1994; Mason, 2002). However, by actively involving participants in certain stages of the research endeavour, such as sharing interview transcripts or analysed data, the process of member-checking can reduce potential bias (Doyle, 2007). Synthesised findings were shared with a random sample of three participants to validate the analysis; and all concurred with the reported findings and categories of themes. Time and lack of availability did not allow for all participants to be involved in member-checking but reported findings will be disseminated and presented to each one. Member-checking is not without its risks, not least because of possible ethical issues if participants become distressed when seeing their words in print or simply disagree with transcripts or analysis (Fossey et al., 2002). However, the lead-author believes that undertaking this step, albeit not always conducted in qualitative research, was worthwhile as it provided some validation that findings represented participants' perspectives and meanings, thereby enhancing the trustworthiness of the study (Morse, 2015; Tong et al., 2007).

Reflexivity

Subjectivity and bias are criticisms often directed at qualitative studies as these can impact on the data and its analysis (Denzin & Lincoln, 2011; Silverman, 2000). As researchers are the 'instrument' in qualitative studies (Patton, 2002) some degree of subjectivity is inevitable, especially as data-analysis relies on researcher interpretation (Jootun et al., 2009). Reflexivity is an essential meta-cognitive process in the endeavour to reduce the impact of subjectivity, minimize the risk of bias and produce qualitative research that is as transparent, trustworthy and credible as possible (Finlay, 2002; Lincoln & Guba, 1985). As a bilingual trainee clinical psychologist, the lead-author was conscious from the outset of the risks of over-identification with participants. She practiced reflexivity throughout by engaging in ongoing self-reflection on how subjectivity and bias, rooted in her beliefs, experiences, knowledge and values, might affect the study, especially during data-gathering and analysis (Finlay & Gough, 2008).

Reflexivity throughout the research process was facilitated by regularly engaging in reflective-practice, capturing reflections in a journal and discussing these in supervision

with co-authors. Reflective practice involved both reflecting ‘in-action’ (in the moment) and retrospectively ‘on-action’ (Schön, 1983). The lead-researcher also practised bracketing (Hycner, 1985; Moustakas, 1994) prior to every interview so that each one was approached with a ‘beginner’s mind’. These practices enhanced her reflective capacity and hopefully minimized the impact of her bias on the research. This process proved invaluable, not least because much of what participants experienced resonated with her own experiences. The lead-author was aware of her values regarding fairness and respect for languages and cultural heritages. However, she had not previously been quite as aware of what it meant to be able work bilingually and how this can differ across contexts.

Ethics

This study was guided throughout by Bangor University and BPS ethical codes of practice on research involving human subjects. Ethical approval was granted by Bangor University School of Psychology Ethics Committee (Ref:2020-16771). The proposed study protocol (Appendix G) was also approved by Health Research Council (Wales) and registered with the health board’s R&D department. As participants were members of staff and not patients, ethical approval by NHS Research Ethics Committee was not required.

Findings

Analysis of data identified three themes, two of which had sub-themes:

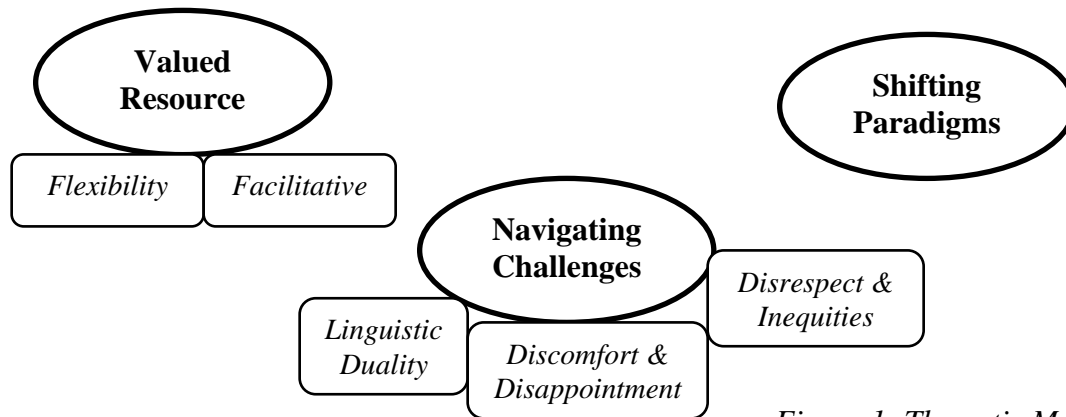


Figure 1: Thematic Map

Theme 1: Valued Resource

Across all participants, the capacity to work in clients' L1 was appreciated as a resource that could be used flexibly to facilitate psychological processes and outcomes. Within the sub-themes of *'Facilitative'* and *'Flexibility'*, being bilingual was experienced and perceived as a Valued Resource at both intrapersonal and interpersonal levels.

Facilitative

Their ability to communicate in Welsh was highly valued by all participants, who understood and could identify with the benefit to clients of L1 communication: *"I'm really pleased I'm able to use my ability to speak Welsh and know that could really help a lot of people because I know myself, sometimes it's a lot easier to explain things in your first-language"* (P2). This capability also fostered pride and self-efficacy: *"I'm really proud of the fact that I can speak Welsh, able to speak with patients in their own language, give Welsh-speakers that choice"* (P7). As well as facilitating emotional expression, many felt that offering a service in clients' L1 mitigated the cognitive load for people already finding communication difficult due to distress or impairment: *"it takes a layer of processing away, makes it easier for them to be able to share things"* (P7).

Participants empathised with clients in such situations, especially those for whom *“one language is enough to deal with”* (P9). Some were also aware that Welsh-speakers can sometimes feel ashamed of their English-language proficiency which *“triggers anxiety that they must get it right”* (P7) and worries that *“people might look down on them If I’m unable to speak English well enough”* (P8). Some identified with this personally, feeling less apprehension *“when I’m working with Welsh-speakers I can just go in there and just do the work”* (P1). Being able to communicate in people’s L1 was also experienced as minimising the distraction and disruption of translation. As one participant had found with distressed clients, being confined to using L2 *“wouldn’t have had the same flow, something would have been lost; you just can’t translate sometimes, every word doesn’t translate directly; and you can lose the emotion as well”* (P9).

Participants felt their ability to communicate in clients’ L1 was a resource which enhanced the therapeutic relationship and facilitated the psychological work: *“doesn’t matter what work I’m doing, whichever intervention, it’s what we create in the middle through language, in that space between us, that’s the critical bit”* (P5). Several participants had experienced welcoming and appreciative responses from Welsh L1 clients when offered Welsh-medium psychological services: *“his visible relief, how pleased he was that he was able to have his treatment in Welsh”* (P9). Several participants felt that the ability to speak Welsh with clients thus facilitated the therapeutic relationship: *“it really helps break the ice, to make someone feel comfortable, helps communication”* (P6); *“makes it a bit easier to make that connection, build that relationship a bit more quickly because you share the same language”* (P7).

The facilitative impact of ease and familiarity when speaking clients’ L1 was particularly emphasised: *“puts them so much more at ease because it’s so familiar and comfortable”* (P7). This feeling resonated with some participants’ own experiences of working in Welsh: *“how comfortable that felt, easier, pleasant even...I don’t know why, just feels easier for some reason and much more comfortable”* (P9). In attempting to articulate this sense of ease and comfort, P7 reflected on the how elusive it was to convey: *“it’s experiential and without being able to do it, you just cannot understand just how comfortable it feels to be*

able to speak Welsh to somebody Welsh” (P7). However, as P9 experienced, such familiarity could also blur boundaries with some Welsh-speakers: “it seems to be a Welsh thing to ask ‘where are you from exactly?’ as if the boundary wasn't so clear, that this was a professional relationship” (P9). As some participants reflected, being a Welsh-speaker provided a kind of heuristic which communicated shared understanding of clients’ socio-cultural contexts: “you don't have to persuade them that you understand them and the environment where they've grown up or live in” (P2).

Flexibility

Although most clients typically favoured one language over another, participants acknowledged the diversity of their clients’ linguistic contexts and how they often switched languages. The ability to adapt and accommodate this was widely recognised, reflecting the mutual flexibility involved: *“undoubtedly the ability to speak whichever language they want to speak certainly helps” (P6). All participants used their bilingualism flexibly across all aspects of their psychological work, often providing input in both languages simultaneously: “very often I translate in the moment” (P1). Being adaptable and switching languages in accordance with clients’ preferences and individual needs was considered paramount: “the key thing is flexibility; flexibility is so very important especially when working with people who are vulnerable” (P9). Bilingualism was thus perceived as a resource which gave clients options: “if you have the ability, it’s very important that choice is there and open to people at all times” (P3). As one participant stressed, remaining open at all times to clients’ preferences and needs was deemed critical: “because sometimes being able to describe things in English is a lot easier for people but not all the time, basically you just can't take anything for granted or make any assumptions” (P8).*

This commitment required attending very closely for cues: *“I always try to go with the language they use and prefer, so I zone in, listening to whether it’s English or Welsh” (P1); “when I meet someone for the first time I listen very carefully to which words they use, so I can pitch” (P3). A few conceptualised being “able to match their language at a level that they feel ok with” (P6) as “another means of establishing “attunement” (P4). Another framed this process as a metaphorical dance because psychological work demands being*

attuned linguistically to be effective: *“in a dance if one partner doesn't catch the other one, they can fall”* (P5). Often language-matching entailed blending both English and Welsh in order to adapt to clients' needs and their system's linguistic contexts: *“not just English or Welsh but the language that they and the family uses, that's so important”* (P6). Clients' unique needs were emphasised by several: *“there is no one-size-fits-all, it's not like that, different things suit different people...and they should have that opportunity to do the work in the language that's right for them”* (P5). When delivering psychological interventions, many participants had also developed and/or used resources in both languages so that Welsh L1 clients' preferences could be accommodated. This helped ensure more accurate comprehension and reinforced learning: *“some choose to have handouts in Welsh, some the English versions and some choose to have both because sometimes they might already have learned some things in English”* (P1).

Most participants found that clients would take the lead on which language they preferred to use and were fully accepting of their agency: *“we started off speaking English but then after the 3rd session she had turned to Welsh and that's what we used for the remaining sessions”* (P1). In some cases, language-switching prevailed throughout as clients might: *“start off in Welsh but then switch to English and from English to Welsh and back and forth and that's ok”* (P8). Several had experienced how clients used language-switching to distance from emotional pain: *“because she'd been able to speak in English about what was going on for her, what she been through, she'd been able to put some emotional distance between herself and what had happened to her”* (P5). Participants also found that clients switched languages, often automatically, to match the linguistic salience and context of their experiences: *“she mainly spoke Welsh but when telling me about what had happened to her in an English-speaking context, she spoke English, automatically slipped into speaking English”* (P3).

Theme 2: Navigating Difficulties

While bilingualism was highly valued by all participants, working as Welsh-speaking clinical psychologists across North Wales also presented various challenges which were experienced on personal, interpersonal and systemic levels. The difficulties they navigated

as trainees and qualified practitioners encompassed three sub-themes: *'Linguistic Duality'*; *'Discomfort & Disappointment'*, and *'Disrespect & Inequities'*.

Linguistic Duality

The ability to speak Welsh was integral to several participants' selfhood: *"the language is really important to me, it's part of my identity"* (P7). However, while some participants worked in settings where their use of Welsh was substantial, for almost all participants their *"professional life is mainly English"* (P3). For most this experience was in stark contrast to their personal lives and formative years, which had been predominantly if not entirely Welsh-speaking. Several felt they had developed distinct linguistic domains: *"you sort of develop two heads, your psychology/academic head which is English and your everyday head which is Welsh"* (P1). For those whose early life and education had been almost entirely Welsh-speaking, entering the predominantly English-speaking world of psychology in higher education and healthcare had initially proved a *"shock to the system"* (P1; P3; P5).

While proficiency and confidence in English had developed, most felt their Welsh professional lexicon had not: *"there are so many words in psychology that I have no idea what their equivalent is in Welsh"* (P7); *these terms sound more natural somehow in English because you've heard them all before, they are more familiar*" (P2); *"I have the terminology at my fingertips in English"* (P4). Even when working with L1 Welsh clients, most participants still drew on English lexicon, especially for familiar psychological terminology: *"I throw in English words when I speak Welsh for example when I'm using CBT - I've never looked up what CBT is in Welsh!"* (P2). Nonetheless, a few participants felt able to make better sense of terms when seeing Welsh versions which conveyed the essence of meaning more appropriately: *"ANOVA was just a word to me until I saw the term in Welsh...it was a light-bulb moment"* (P1); *"words like 'canolbwyntio' [literal translation: 'middle-pointing'] are just brilliant, 'concentration' just doesn't convey meaning in the same way"* (P4).

Participants expressed strong emotional attachment to the Welsh language and several felt, some with explicit regret, that it had been neglected and even diminished in their professional contexts: *“I think I've lost something there, in that my Welsh hasn't had the same attention and opportunity to develop”* (P5); *“without doubt, the language of my heart is Welsh and the language of my head is English and part of me is sad to say that English is the language of my intellect but that's the truth”* (P4). Despite being Welsh-L1, due to the predominantly English-language context of their academic and professional development, several were aware of this duality, feeling *“embarrassed we don't have the [Welsh] terms”* (P5).

This was particularly salient when working with clients or in contexts where Welsh-language standards were high: *“sometimes it's difficult when both [languages] come together”* (P1). As participants reflected *“there are different levels of Welsh and someone like me, brought up speaking Welsh at home wouldn't necessarily use more formal Welsh”* (P1). Even participants from entirely Welsh-speaking backgrounds had experienced an almost self-stigmatising feeling that their Welsh-language proficiency *“wasn't good enough”* (P1) when working with people whose Welsh-language was *“of higher quality”* compared to their *“messy Welsh”* (P4). Focusing on Welsh-language correctness in a professional context had proved problematic to a few participants as that distraction: *“makes it so easy to trip up and almost diminish the value of what I'm trying to convey, because of worrying about the language”* (P4).

Ironically some participants also experienced the opposite when *“trying hard to sound professional”* by minimising their Welsh-colloquialism, finding that some clients had *“been put off”* (P9); *“didn't feel comfortable speaking with me because he felt my Welsh was too highbrow”* (P4). This had been surprising and dissonant as, typically, Welsh-L1 speakers are comfortable speaking Welsh, even if their preference is for formal documents to be in English/bilingual. However, as some reflected, service-users often interact with several parts of the health service which, more often than not, is English-medium and therefore English is more familiar and expected: *“other professionals in the service who would have been in contact with him and it's English that they would have spoken”* (P9);

“because they’re used to having an English-medium service they think that’s what they should do” (P8). Feeling the need to comply with the prevailing language of the service/health professionals was seen by some as indicative of the historic *“power-imbalance”* associated with the Welsh-language: *“what went on in schools, just a few decades ago, you were made to feel inferior if you used the Welsh language”* (P7).

Discomfort and Disappointment

The dearth of Welsh-speaking clinical psychologists in certain parts of the service highlighted for several participants the extent to which they were a minority: *“there aren’t that many psychologists who can speak Welsh so you really do feel like you’re in the minority”* (P7). Many reflected on why clinical psychology was not attracting as many Welsh-speakers as other vocations. Some hypothesised that perhaps social-identification with the profession was impacted by the predominantly *“white, middle-class, Anglicised image”* (P3; P7; P8) of a profession intended for *“really intelligent English people, not a Welsh person like me”* (P1). Although successful track records had eventually disabused participants of such notions, some acknowledged there was persistence to professional self-efficacy beliefs that *“I’m not really good enough to be a clinical psychologist”* (P1). While the competitiveness of professional training for everyone was acknowledged, being in the minority as *“the only Welsh-speaking trainee”* (P2) on training programmes in Wales had perpetuated self-doubt and some discomfort that they were simply *“the token Welsh person”* (P4; P7; P9).

For some participants, the discomfort of being in the minority had been compounded by others’ lack of knowledge of Welsh language and culture and/or an understanding of the impact of being bilingual. From trainees on Welsh programmes who *“had no idea there was such a thing as a Welsh language”* (P1) to comments from colleagues that Welsh-speakers *“can all speak English anyway can’t they, they watch English television don’t they?”* (P7) such experiences had proved disappointing, particularly within a psychological context. Participants were happy to inform colleagues about Welsh language and culture: *“I did a lot of educating as a trainee but hopefully in a light-hearted, interesting way!”* (P1). However, there was also an acknowledged reticence and discomfort regarding being

perceived as defensive and “*Welsh nationalist*” (P2; P7). One participant’s experience, when highlighting the needs of Welsh-speaking clients, was that: “*people would look at me as if I’d sprouted horns, they just didn’t realise...but sometimes it can feel very unpleasant, you feel like the freak in the room*” (P3).

Consequently, participants welcomed input from English colleagues in educational sessions: “*giving their insights and perspectives on working in Welsh-speaking contexts, which was more powerful in a way*” (P9); “*one of the things that was so good about the session was a non-Welsh speaker designed and delivered it, so it didn’t seem to feel as threatening or uncomfortable in some ways*” (P1). As one participant observed, when trying to explain the importance of bilingual mental health services and occasionally encountering negative responses “*it can be very emotional talking about the [Welsh] language*” (P1). Participants were therefore highly appreciative of the efforts English-L1 colleagues made to learn Welsh and/or the degree to which they demonstrated cultural sensitivity to clients’ contexts: “*they’ve made massive efforts to learn Welsh and though they might not be very fluent, they understand quite a lot of the language but more importantly they really understand the cultural context that we’re working in*” (P6); “*though she couldn’t speak Welsh she really respected and was incredibly sensitive to issues around language and culture and the Welsh language*” (P9). Regardless of emotional attachment to Welsh-language and cultural heritage, for all participants the ultimate importance of understanding clients’ linguistic and cultural contexts was psychological: “*as a psychologist you don’t have to understand the language but you need to understand the fact that they have other languages, how they all operate differently and so on, it’s not just about rights...we are psychologists, not politicians or Welsh-language advocates so you have to leave that baggage behind*” (P3).

Disrespect and Inequities

A small number of participants had unfortunately experienced prejudicial and disrespectful comments from clients and occasionally from colleagues, including mental health professionals. One participant had been at the receiving end of disrespectful comments that success in numerous job applications was due to Welsh-speaking ability: “*colleagues*

saying you obviously got the job 'cos you can speak Welsh, nobody else had a chance...it's been there off and on all the way through, that you have sneaked in somehow" (P2). Other similar but more general prejudicial comments came from *"health professionals saying they wish they hadn't moved here because people aren't intelligent enough, even MDT staff aren't as intelligent as those working in England"* (P2).

Others had experienced less blatant but nonetheless equally disrespectful *"dismissive attitudes towards the language"* (P7) which some reframed as possibly *"defensive"* (P7; P8; P9) behaviours. As P8 reflected, a more constructive but steadfast response to attitudes that bilingualism/Welsh-language is *"a burden"* is to *"retain openness, an easy manner, you can't be too single-minded or stubborn about it...try to persuade and stay positive, demonstrate good examples and keep ploughing on"* (P8). Nonetheless, experiences of disrespect and dismissiveness had been *"very unpleasant, very difficult, happened a fair bit"* (P3) and *"hurtful"* (P8). While one participant was able to minimise personal experiences: *"it's ridiculous, I just think to myself, for goodness sake"*, there was, nonetheless, concern for others: *"when you think of all the vulnerable people they are working with, it's a bit worrying"* (P8).

Participants in predominantly Welsh-speaking contexts also felt it was *"rude and disrespectful"* (P6) for discussions in Welsh to take place without a translator if non-Welsh speakers were present. Another participant captured the internalised conflict and dilemma of relatively uncommon contexts where the majority of professionals are Welsh-speakers: *"in that situation I would try to include them, maybe translating a bit of the conversation, saying to them you know we're not talking about anything, just rubbish about television programmes or whatever...but it is very difficult cos you don't want to make people change the language that they would naturally be speaking...but you don't want to exclude anybody either...or have people being defensive about it"* (P9).

Most participants expressed concern for the injustices, disadvantages and unmet needs of Welsh-speaking clients and families seeking mental health Welsh-language services. In addition to the dearth of bilingual practitioners available to provide Welsh-language

interventions, some participants had also experienced unfortunate incidents during assessments where language misinterpretation presented risks: *“very often you’d have professional people who couldn’t speak Welsh misunderstanding clients, sometimes making serious mistakes in their understanding of people”* (P8). Even where bilingual services were available, the disadvantage of English-medium, standardized psychometric tests was challenging for several participants, many of whom opted to translate where necessary. While acknowledging and being transparent in reports regarding the impact on validity of providing bilingual instructions and translating certain words/phrases, ensuring such assessments provided accurate representations of clients was considered paramount: *“so much better than persisting with the cognitive assessment in English when the individual just doesn’t understand”* (P6). Priority was given to clients’ needs and minimising adverse impacts *“which is much fairer than putting them through an English-only test where their anxiety then just increases even more”* (P1). As one participant experienced, by carrying out standardised psychometrics in a *“‘pure way’ I know I wouldn’t get the information I need which is far more important, so I will use the language I need to obtain that knowledge, give us a greater chance of getting a picture that is more representative and accurate about what is going on for that person”* (P7).

Theme 3: Shifting Paradigms

Despite the various challenges participants faced, the theme of shifting paradigms encompassed the largely constructive changes participants were experiencing at systemic and personal levels. Many participants, particularly those with longer service, felt that there had been a palpable shift in understanding and recognition of the importance of accessing Welsh-medium/bilingual clinical psychology services. As one participant observed, within services: *“things have changed radically, you see posters everywhere now encouraging people to learn Welsh...the door has opened somehow, you don’t have to knock on it anymore just give it a gentle push, things are much more positive now”* (P3). Some areas were proactively supporting staff to learn and/or enhance Welsh proficiency by providing bespoke interventions to meet varying needs, from learners to L1 Welsh-speakers. This had been highly welcomed by one participant who needed: *“to become more familiar with some of the terms, support with writing formal reports and emails...I learned some*

valuable tips” (P6). Participants still felt, however, that more needed to be done to increase access to Welsh-medium psychology services as it still did not fully: *“reflect the social context”* (P1). As another observed: *“you see the need everywhere, every day”* (P3). There was however some optimism that recognition of this need and the momentum for constructive change was growing with *“more people shining a light on this, it gets a bit more attention and eventually the message will get through and hopefully deepen the discourse”* (P5).

The local clinical training programme was viewed as having increased its support and commitment to bilingual trainees. Previous perception was that *“there wasn’t really much encouragement for Welsh speakers to apply”* (P8). However, recent experiences were more constructive: *“it’s a really good thing the programme sees the need for more psychologists who can speak Welsh, shows that they’re listening, things have shifted more recently”* (P1); *“the programme has become much more positive and though there is still some way to go, there’s a bit more respect towards the Welsh language now”* (P8). Several participants had taken the initiative to address the dearth of bilingual practitioners and the issue of attracting more Welsh-speakers by publicising the profession/programme among psychology undergraduates and sixth-formers: *“to highlight to young people that this is a potential career option* (P1); *“and how the service and profession needs Welsh-speakers because there’s a need to do that and early on”* (P9). Others recognised the value of efforts made to enhance Welsh-language psychology provision by practitioners but still wished that, within the system, there was *“a bit more commitment to and recognition of all the efforts being made, people have done some really good work translating some of the models and interventions into Welsh so they’re available to psychologists”* (P5).

Several participants wished to see greater facilitation of the nuanced and often highly individualised way in which Welsh-speaking clients chose to use their bilingualism become more of the norm: *“a lot more could be done to make it much more natural for people to be able to switch backwards and forwards from Welsh to English and back again if that’s what [clients] want...at the moment it’s just too binary...needs to be normalised that there is a choice for people”* (P8). As many observed, bilingual psychologists need to reflect on

this particularly unique aspect of their clinical practice, possibly with peer-support which had previously been available and many wished to see resurrected. Reflecting on personal experience, one participant advocated having the confidence to embrace a less absolute and rigid attitude towards language choice: *“what I’d encourage bilingual practitioners to do is to just let the language ‘be’, ‘cos it’s just a way to communicate and convey meaning, so it doesn’t really matter if it’s Welsh or English or somewhere in between really, not in a therapeutic, psychological context”* (P4).

The following table illustrates further transcript extracts supporting each theme and subtheme:

Table 1: Examples of Illustrative Transcript Extracts per Sub-theme and Theme

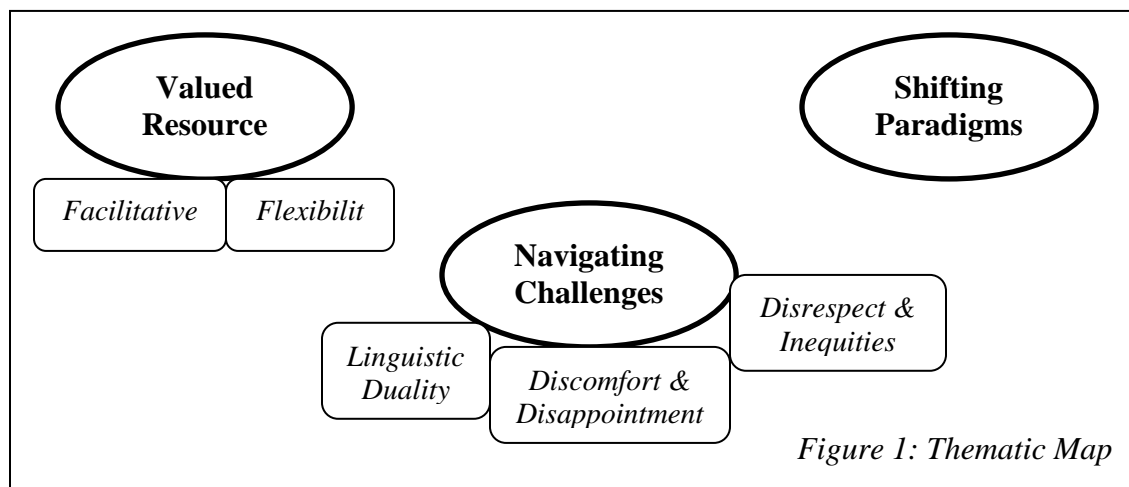
Theme	Sub-theme	Illustrative Extract from Transcript
Theme 1: Valued Resource	<i>Facilitative</i>	<p>I know myself that when I have to go to see a doctor or something And maybe I have something big or difficult to say I find yourself thinking, I hope he or she can speak Welsh (P2)</p> <p>there are words in the Welsh language which don't convey the same meaning so if you're having to articulate and describe your experiences in English, you might not be able to convey the same depth of meaning...if we're struggling emotionally or psychologically, then we need something which helps us...not work against us and make it even harder" (P5)</p> <p>I think language really is like another way of creating attunement with clients and whichever language they use, the main thing is that they are able to express their emotions which can be so strong (P4)</p> <p>When you speak their language, talk to them in their own language, you're on their level (P7)</p> <p>When working with cognitive impairment or decline, I've had several family say to me they want to speak in their first language (P6)</p>
	<i>Flexibility</i>	<p>With this one client, who had almost become fully bilingual really, she would then just say during sessions 'I need to say this in English', because even though she could speak Welsh very well, English was her first language". (P3)</p> <p>Very often I will only use or speak English when I'm with my clients or some clients have can't speak Welsh but in office I could speak welsh all day (P2)</p> <p>I often find myself working bilingually...like with a current client I have, where I'm working with him on English but with his relative I speak Welsh, cos it's his choice and it's in English that he wants to present himself to the world (P1)</p> <p>so when we ran the course, we said you're welcome to speak to us, ask questions or make comment in Welsh and we will speak Welsh with you but the course will be delivered in English because not everyone understands Welsh (P3)</p> <p>Quite often I'll be working with a family where, say mum is Welsh but dad might be English, or maybe the grandparents are English (P6)</p>
Theme 2: Navigating Difficulties	<i>Linguistic Duality</i>	<p>I'm now in a job where unfortunately there's very little opportunity to work in Welsh so I don't get to use my Welsh much...but at home and with my friends, I speak Welsh most of the time (P9)</p> <p>I went to a Welsh school, spoke Welsh all the time growing up...but there are so many words in psychology that I have no idea whatsoever what their equivalent is in Welsh (P7)</p> <p>I still find it hard sometimes and find myself thinking 'so how do I best say this in English, am I saying this correctly?' (P1)</p> <p>I've been bilingual from an early age but see myself very much as a first language Welsh speaker, although every interview I've had over the past few years has been through the medium of English (P6)</p>

	<p><i>Discomfort and Disappointment</i></p> <hr/> <p><i>Disrespect and Inequities</i></p>	<p>In one team, there wasn't a single member of staff who spoke Welsh so I said if there's any Welsh speaking clients, I can speak Welsh if you want me to take on those referrals but they just looked at me blankly (P9)</p> <p>The conversation did not go well at all when I was trying to explain about the people we work with who are Welsh first language. It can feel very uncomfortable when there is no understanding of how it can really matter to people, that they are able speak in their first language (P1)</p> <p>I've had people in my own profession saying 'it doesn't really matter if you do the assessment in English because you'll get you'll get an idea anyway'. (P5)</p> <p>You are in the minority as a Welsh speaking clinical psychologist, a very small minority...so there is a power imbalance and it's easy to feel a bit subservient I suppose (P7)</p> <hr/> <p>It's very difficult and so unfair when you know there are patients who really need to be able to speak Welsh but the service can't offer that (P1)</p> <p>I have come across a fair bit of negativity when there's been discussions about Welsh language and culture (P9)</p> <p>You can get a lot of very dismissive attitudes towards the Welsh language sometimes – sort of why do we need to bother to do that then, you know about providing bilingual service (P7)</p> <p>Happens so often, I'm greeted with 'at last somebody who can speak Welsh, I don't think people have really understood how I feel when I try to explain in English' (P8)</p>
<p>Theme 3: Shifting Paradigms</p>		<p>The service was very anglicised when I started but I do think that since then things have changed a lot (P3)</p> <p>I think it'd be a lot easier if I've stopped worrying about whether my language is of a high quality or not...after all languages evolve don't they, Welsh or English they've changed a lot over the centuries (P4)</p> <p>I think the service could be doing an awful lot more to promote the Welsh language and to make it much more natural for people to be able to switch backwards and forwards from Welsh to English and back again, if that's what they [patients] want (P8)</p> <p>The more things like this [research project] is shining a light on these issues around language, bringing a bit more attention to it, things begin to develop and I think this will eventually get the message through and hopefully deepen the discourse, so there's a bit more substance to those discussions (P5)</p> <p>so the teaching on Welsh language and culture is definitely a good thing (P4)</p> <p>There's much more room to do much more than we're doing at the moment, there should more commitment and scaffolding to support us to do this [provide Welsh-medium psychology service] rather than just simply paying lip service (P5)</p>

Discussion

This study sought to explore and gain a qualitative understanding of perceptions and experiences of bilingual Welsh-English clinical psychologists practising in North Wales, which hitherto had not been examined. Limited research available into the phenomenon of bilingualism and psychological therapy has largely emanated from North America, focusing predominantly on Hispanic populations. Findings from a qualitative analysis of participants' perceptions and experiences indicated that working as a Welsh-speaking bilingual clinical psychologist was complex, nuanced and evolving. There was a dialectic quality to their experiences and perceptions, being simultaneously challenging and conflicted as well as positive and constructive for all participants to varying degrees. Participants' experiences and perceptions were also contextual across systemic, interpersonal and intrapersonal dimensions.

Analysis of participants' data produced three main themes, which largely reflect extant literature on bilingual psychological therapy:



The theme of 'Valued Resource' has been indicated in other studies (Altarriba & Santiago-Rivera, 1994; Dewaele & Costa, 2013) indicating how bilingual psychological practitioners value their bilingualism highly, appreciating the benefits of being able to offer psychological assessment and interventions in clients' L1 and/or language(s) of choice. Experiences of the facilitative aspect of communicating in whichever language clients found most comfortable and the appreciation and relief this elicited resonates with research

involving bilingual psychological therapist/practitioners and clients (Peters et al., 2014; Sciarra & Ponterotto (1991). Studies have also highlighted the value of accommodating automatic language-switching, which resonated with all participants who used their bilingualism to allow clients flexibility and choice in use of language (Costa, 2010).

Working as a Welsh-English bilingual clinical psychologist, is not however, without its difficulties as the theme of 'Navigating Challenges' conveys. Language and identity are inextricably linked (Costa, 2014; Dewaele, 2015) and this study's findings indicated that many participants felt their linguistic identities differed between personal and professional contexts. The sub-theme of 'Linguistic Duality' reflects how English and participants' L2 was experienced as essentially being the language of psychology and their professional lives, in contrast to personal lives where L1 dominated. Experiencing English as the language of psychological therapy and the Anglo-centric emphasis of clinical training has been highlighted (Fondacaro & Harder, 2014; Minas et al., 1994; Wright, 2014). Studies have also shown how lack of knowledge of professional terminology in L1 can lead to feelings of inadequacy and inhibition among bilingual psychological practitioners (Biever et al., 2002; Estrada et al., 2018) as these participants had also experienced.

The paucity of Welsh-speaking clinical psychologists contrasts markedly with other professions in areas where Welsh is widely spoken. In such contexts, multi-disciplinary interactions often led to some participants feeling embarrassed and conflicted regarding their Welsh language proficiency. While this issue has not been explored, challenges of multiple layers of colloquialism and formality in the Welsh-language expressed by several participants have been referred to in the literature (Thomas, 2005). Working in a service with a dearth of Welsh-speakers also meant participants were in a minority among colleagues, can lead to feeling marginalised and tokenistic as many reported. The discomfort that feeling and being different can engender was compounded by disappointment for several participants when encountering cultural insensitivity and lack of awareness of linguistic and cultural differences, captured by the sub-theme of 'Discomfort and Disappointment'.

Experiences captured by the sub-theme of ‘Disrespect and Inequities’ reflect the prejudice some participants had encountered and the inequitable provision of Welsh-medium psychological health services. Instances of disrespect and prejudice towards heritage/minority languages do not appear to have been reported in research examining experiences of bilingual psychological practitioners. While not all participants had encountered blatant prejudice, frustration at the inequity of inadequate access to Welsh-medium services for Welsh-L1 clients was widely expressed. This sub-theme resonates with concerns regarding inadequate provision of psychological therapy in clients’ L1 highlighted in the literature (Liu, 2013; Verdinelli & Biever, 2013). This study’s findings and the concerns of many participants regarding the potential for inaccurate psychological assessments, the inequity and risks posed due to language barriers have been reported in previous studies (Novy et al., 2001; Softas-Nall et al., 2015; Van Loon et al., 2013; Woidneck et al., 2012). Within Wales, such concerns reflect the more general issue of limited provision of and access to Welsh-medium mental and physical healthcare (Madoc-Jones, 2004; Roberts et al., 2004). Lack of access to bilingual psychological services disadvantaged certain groups in a region where large numbers of the population are Welsh-speakers underpinned the sub-theme of Disrespect & Inequities’. Perceptions that addressing this lack of provision was not prioritised were highly dissonant for several participants as Wales is a bilingual country and access to Welsh-language services is a legislative requirement.

The challenging aspects of working as bilingual clinicians were clearly underlined by this study’s participants who were all aware of the negative impact this potentially had on clients as well as themselves. Negative experiences were, however, counterbalanced with optimism that constructive changes were beginning to occur which is reflected in the theme of ‘Shifting Paradigms’. Many perceived that there was an increasing appreciation of the importance of language preference and choice in ensuring effective delivery of psychological assessment and interventions, even if this provision remained inadequate in many areas. Participants also felt there was growing respect for Welsh-L1 clients’ linguistic and cultural heritage; and that encouragement and commitment to supporting Welsh learners was one indicator of this. However, it was the critical and inherent need for greater

awareness and understanding of the psychological impact of bilingualism that most participants advocated and believed was beginning to shift. In particular, the locally situated training programme was now seen as committed to attracting and supporting more bilingual clinical psychologists, even though training programmes for psychological practitioners have been found to be Anglo-centric (Trimble, 2001). The need for a paradigmatic shift and changes on a personal level were also recognised and advocated. Many acknowledged that ongoing commitment to their own professional and personal development could help address issues around linguistic proficiency and self-efficacy beliefs. Some even reflected on how acceptance of a blended approach to language could minimise the distraction of concern for language correctness where this might impede clinical effectiveness (Kapasi & Melluish, 2015).

Clinical Implications and Relevance

Although the focus of this study was on Welsh-speaking bilingual clinical psychologists, its findings have relevance and applicability to bilingual psychological practitioners in any context beyond Wales. This explorative study yielded knowledge and insights which could inform practice and professional development of bilingual clinical psychologists as well as service leadership and planning in relation to bilingual psychological assessments and interventions. Participants' experiences underlined the clear benefits of access to psychological assessment and interventions in clients' L1 and the advantages of being able to engage flexibly with psychological services in their language(s) of choice. Hopefully such insights can be used to inform service leaders and clinicians involved in workforce planning and operational management in order to ensure sufficient provision and thereby increase access to bilingual psychological services.

Awareness of how clinical psychologists experience working bilingually could be of value to managers and supervisors who may not be bilingual themselves. As these participants experienced to varying degrees, the valuable resource of bilingualism can also bring some emotional and cognitive challenges. This study highlighted the impact of developing dual language proficiency and linguistic identities as well as the discomfort of being in a minority; and how these experiences can lead to feeling inhibited and inferior. Findings

also provided insight into how bilingual clinicians can encounter disrespect and lack of understanding regarding the psychological impact of bilingualism; and the dissonance of the disappointingly inadequate access to bilingual psychological services. Although negative experiences were perceived as outweighed by self-efficacy and appreciation of bilingualism as a valued skill, being bilingual can be challenging for practitioners. Increased awareness of such experiences may help facilitate arrangements to support bilingual clinical psychologists, such as occasional access to bilingual supervisors and L1 peer/group supervision. Such support is aligned with the commitment to diversity and cultural and linguistic sensitivity in clinical psychology.

Participants' perceptions and experiences may also be of interest and resonate with other bilingual clinical psychologists who might find this study's findings useful when reflecting on their own bilingual practice. Clinical training programmes in Wales are increasingly committed to attracting more Welsh-speaking trainees and there is a growing recognition of the global need to increase diversity within the profession. It is also hoped that participants' insights will increase awareness of how bilingual trainees can experience clinical training, which may inform initiatives aimed at attracting applicants and supporting their development throughout training and beyond.

Limitations and Future Research

While findings from this exploratory study may provide useful insights for practitioners, supervisors and service leaders, it is nonetheless small-scale and confined to one Welsh health board. Purposive sampling ensured participants had relevant experience of the phenomenon under investigation; and all participants known to meet the inclusion criteria were invited to participate. Although this approach had a good response rate, the perceptions and experiences of a small number who did not come forward, or reasons why they chose not to, has not been captured. Some participants were also known to the lead-author, albeit not well and only via brief acquaintance/meetings in a professional capacity. Nonetheless, this could have been problematic and impacted on the research in a number of ways including discouraging potential recruits and inhibiting disclosure by included participants during data-gathering. Nonetheless, rich data was gathered from nine

participants who all generously and openly shared their experiences and insightful personal reflections with minimal or no probing by the lead-author, despite the use of unstructured interviews. Every effort was made to ensure this qualitative study produced research that was credible and trustworthy, especially given the extent to which the lead-author's status mirrored that of participants. Bracketing personal views and experiences as much as possible and engaging in reflexivity throughout the research process helped reduce subjectivity and bias. However, many of the experiences and perceptions shared by participants resonated with the lead-author's own as a Welsh-speaking bilingual clinical psychology trainee. Despite the methodological rigour applied to gathering and systematically analysing data and efforts to reduce subjectivity, the impact that her personal experiences, values and biases will undoubtedly have had on this study, however small, is acknowledged.

Given the scale of this research and that it is the first study exploring the experiences and perceptions of Welsh-speaking, bilingual clinical psychologists working in Wales, further research is clearly warranted. This qualitative study could be extended beyond one health board to include bilingual Welsh-English clinical psychologists working in other boards and trusts across Wales. Research could also be scaled up with, for example, a survey to capture qualitative data with a sample of follow-up interviews. There is also a dearth of research exploring the experiences of bilingual clinical psychologists globally and therefore more scalable research, such as a survey, could begin to address this wide gap in the literature across multiple contexts. Participants' flexible use of language-switching and language blending during clinical work also warrants further research, in particular the potential role it could play in therapeutic change. Extant literature has indicated how words are not always translatable and can be more or less emotionally-laden and salient depending on language fluency or contexts of experiences. There is a need for more knowledge and deeper understanding of the use and impact of language switching by both parties to the therapeutic dyad during psychological assessments and interventions.

Conclusion

This small-scale, initial exploration involving bilingual, Welsh-English clinical psychologist highlighted how complex, nuanced, multi-dimensional and evolving their experiences as practicing clinicians can be. Their experiences had a dialectical quality wherein the ability to work bilingually was highly valued as a rich resource, while simultaneously bringing challenges to be navigated. Being able to work bilingually was cherished as providing person-centred flexibility that enhanced clinical psychology practice. Working bilingually did, however, create linguistic duality and could at times be uncomfortable and disappointing, especially in instances of prejudice and persistent inequities where services did not meet the needs of Welsh-speakers. Proactive commitments to recruiting more Welsh-speaking clinical psychologists and supporting Welsh-language learning/proficiency were, however, seen as a positive shift towards addressing language choice and the unmet language needs of Welsh L1 clients and service users. While many perceived that there was a growing appreciation of the importance and impact of language choice in clinical psychological work, they also felt that there was still more to be done. In a similar vein, much more research is needed to address the gap in knowledge than this first explorative study of bilingual clinical psychology practice has yielded, albeit a starting point in that endeavour.

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Section 3 – Reflective Paper

Contributions to Theory and Clinical Practice

Both the Empirical and Literature Review papers have focused on two distinct groups who have hitherto been largely overlooked within the context of mental healthcare. Findings from both papers have implications for clinical practice, make some contribution to theoretical frameworks and identify areas that warrant further research. The aim of this paper is to consider potential contributions to and implications for future research, theory development and clinical practice that have emerged for the lead-author as a result of undertaking this study. Some additional personal reflections on the research process for the project as a whole will also be described.

Implications for Future Research & Theory Development

Ecological Systemic Theory

Findings from both papers highlighted the impact of ecological systemic factors on the experiences and perceptions of participants from two distinct but often marginalised and overlooked groups. How language and cultural heritage influenced the values and beliefs of bilingual clinical psychologists and the impact of ecological systemic contexts on their selfhoods and psychological responses over time was evident. Having a different linguistic identity within their homes and personal lives, in contrast to work and professional lives, illustrates the often conflicted interaction between these life-domains. Interpersonal interactions, attitudes and behaviours of others within various contexts also impacted on their experiences as bilingual practitioners, shaping their world-view and self-concept. Their experiences and perceptions were also clearly impacted by wider systemic issues within their work contexts, at both local and national levels within health and governmental systems.

Similarly, young-carers' experiences highlighted a dichotomy of individual responses to their care-giving situations, which were also clearly influenced by interactions at familial and friendship levels. Here again the impact of the wider systems of health, social-care and educational institutions and services as well as socio-economic factors were also clear. Within their immediate environment, how caring was experienced depended on how young-carers adapted to their caring roles, found ways to mitigate negative experiencing

and optimise skills and strengths acquired. Relationships with care-recipients, their conditions, support from family, close friendship circles, teachers and health and social-care professionals all interacted and influenced how extensive the care-burden and adverse experiences could be for young-carers.

Thus the extent to which systemic factors at more immediate and broader levels impacted on participants in both studies underline the relevance of a model that takes account of multidimensional, systemic contexts. Although originally conceptualised within developmental psychology, Bronfenbrenner's (1977) Ecological Systems Theory has relevance to and is increasingly used in community clinical psychological contexts (Eriksson et al., 2018; Jason & Aase, 2016). This theoretical model provides a more detailed representation of the complex interplay between concentric systemic factors and their impact on individuals within their multilevel ecosystems over time. It brings an added dimension to the biopsychosocial model (Engel, 1980) which is firmly established within specialisms such as clinical health psychology research and practice (Lehman et al., 2017; Wade & Halligan, 2017). Consequently, the ecological systems model is increasingly viewed as having greater value for multidisciplinary and community-based interventions and research. In their work to develop a theoretical framework for young people's mental health recovery, Kelly and Coughlan (2019) highlighted how key aspects of recovery are embedded in ecological systems aligned to Bronfenbrenner's model.

On reflection, ecological systems theory certainly had salience for both these small-scale qualitative studies. It also has broader usefulness and relevance for clinical psychology in how it extends and complements a biopsychosocial approach. In a small way perhaps these studies lend further weight to the usefulness and relevance of Bronfenbrenner's (1977) model in exploring and examining psychological phenomena within the context of their ecological systems. The literature review highlighted the need for more research exploring the experiences of young-carers, especially in Wales where, systemically, substantial efforts have been made to support this vulnerable, easily overlooked group. Research into the experiences of bilingual clinical psychologists also needs to be extended much further. Bronfenbrenner's (1974) model could provide a guiding framework in qualitative research

with a phenomenological design, especially as human experiences of a phenomenon are inevitably influenced and their perceptions shaped by their various micro, meso, exo and macro-systems over time (chrono).

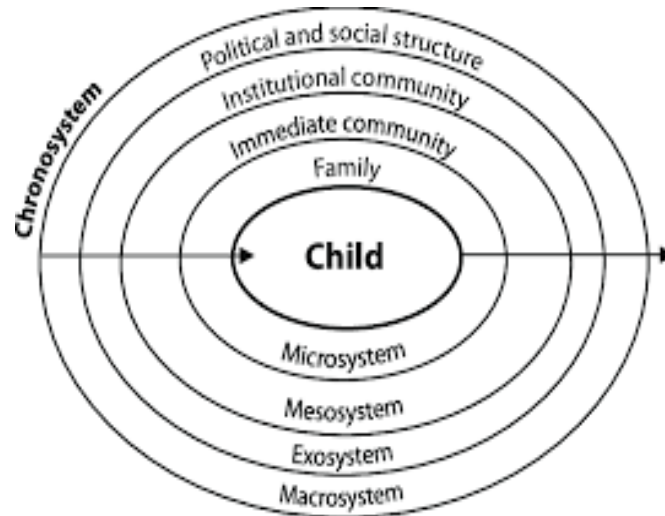


Figure 1: Bronfenbrenner's (1977) Ecological Systems

Inclusivity

Researching groups that are often overlooked highlighted the issue of inclusion and involvement in research within the realms of mental health and wellbeing. Driven predominantly by the UN Convention on the Rights of the Child (United Nations General Assembly, 1989) ensuring that children and young people's voices are heard in research has gained more attention in recent years (Tay-Lim & Lim, 2019). The substantial increase in research involving young-carers is positive and indicative of the growing recognition that support for this group of young people needs to be better understood and met.

However, focus on research with young-carers is inconsistent, as indicated by the lack of research involving young-carers in ethnic minority communities and in countries like Wales since Thomas et al. (2003). However, Wales has made progress with legislation and policy measures. The Social Services and Well-being (Wales) Act 2014 makes provisions to ensure young-carers can access their right to support. Carers Trust (Wales) in collaboration with the Welsh Government produced a briefing to inform educational establishments of young-carers' rights (Carers Trust, 2020). How well schools and colleges

support the education of young-carers is a measure now incorporated in within secondary schools' and colleges' inspection reports (Estyn, 2019). Perhaps in the wake of such constructive and proactive developments, the gap in research involving young-carers in Wales will be addressed.

Reviewing young-carer literature also demonstrated the progress made by some researchers to design more accessible, 'child-friendly' methodologies to ensure young children's voices are heard. A couple of reviewed studies with young-carers used creative methods such as images, drawings and cameras to elicit and gather data from their young participants. These participatory methods have been found to be effective in encouraging children to engage in research and seen as shifting power imbalances and the paradigmatic emphasis from research *on* to research *with* young people (Thomson, 2008; Einarsdottir et al., 2009). Such participatory methods are increasingly used within educational and developmental psychological research. While there has to be some caution regarding ethical use of creative methods such as filming, consideration should be given to their wider use in research with children and young people in mental health contexts (Morrow, 2012).

These participatory, inclusive methods are particularly salient when working with young people where severe mental health issues, learning disabilities and/or language difficulties present additional barriers and exclusions. Empirical research with bilingual clinical psychologists indicated the importance of addressing inequities resulting from inadequate Welsh-language provision within the health service in Wales. It is therefore essential to consider whether language forms a barrier excluding certain groups from research. Power imbalances within the research process have been extensively debated (Karnieli-Miller et al., 2009). That there had not been a previous study of Welsh-speaking bilingual clinical psychologists suggests there may also be a power imbalance in contexts and *where* research interests are focused, potentially perpetuating the exclusion of marginalised groups and communities (Parson, 2019; Wallerstein et al., 2019).

Participants' experiences in the empirical study largely reflect the emerging and sparse extant literature on bilingual psychological therapy practice. However, given the paucity

of studies, much more research is warranted, especially as the importance of language for psychological work and problematic aspects of language barriers in healthcare are well-established (Bauer & Alegria, 2010; Richards, 2018). Furthermore, experiences such as marginalisation, other people's negative attitudes and prejudice have not been widely reported in existing research involving bilingual psychological therapists. Given the potentially adverse impact of such experiences on practitioners and clients, this is a gap in knowledge that needs to be addressed and expanded further than this small-scale study. The lead-author has also since reflected on how participants' experiences of switching and blending languages during their clinical work is closely aligned with 'translanguaging', a concept and practice which emanated from Wales and increasingly used in bilingual education worldwide to reinforce learning (Baker, 2011; Williams, 2011). Given that therapeutic change also involves new learning, further investigation into the flexible use of languages among bilingual clinical psychologists could yield useful knowledge that has relevance wherever psychological practitioners work with bi/multilingual people.

Growth from Adversity

Post-traumatic growth theory has arguably offered some hope for people who have experienced adversity and trauma that not only is recovery possible but it can also bring transformational, positive change in its wake (Tedeschi & Calhoun, 2004). There have been extensive reports of people experiencing positive changes in affect, enhanced self-esteem, life-goals and relationships across a range of adverse experiences and traumatic events (Linley & Joseph, 2004). Research in the area of growth from adversity or post-trauma is evolving, however, with some emerging debate as to whether type of trauma or adverse experiences influences the potential for subsequent growth (Brooks et al., 2019). Studies have shown less growth in relation to adverse and traumatic events resulting from interpersonal relationships and deliberate actions and intentions to harm by others, compared with events such as natural disasters and unexpected bereavement (Kılıç et al., 2016; Shakespeare-Finch & Armstrong, 2010).

Young-carers experiences highlighted how, for some, it was possible to grow and develop despite adversity. Many, however, did not - typically in circumstances where adverse

experiences were due to neglect or abuse. This resonates with research suggesting that post-traumatic growth is not as strongly associated with trauma resulting from the actions of others. However, where experiences indicative of growth were reported, young-carers reported being able to reframe negative thoughts; generalise skills and strengths acquired to other life domains; feel appreciative; and find meaning in their care-giving roles. Such experiences and reports of experiencing positive affect and developing resilience chime with aspects of positive psychology and its strength-based, positive affect focus (Seligman et al., 2005). Rooted in humanistic psychology and originally developed to enhance wellbeing of psychologically healthy individuals, evidence of its effectiveness as an adjunct or alternative to established, evidence-based interventions in clinical settings is increasing (Stone, 2018). Research examining how young-carers (and other groups) have coped with adverse experiences could yield valuable insights, especially as post-intervention studies examining the impact of learning positive psychological skills and strategies.

In their work as bilingual clinical psychologists, the inequities, prejudices and discomfort many participants experienced were aversive. Navigating challenges was a key theme of their experiences as practitioners and leaders in a profession that is considered to be stressful enough (Hannigan et al., 2004) without the added dimension of negative experiences these participants reported. Many, however, had reframed the challenges and negative aspects of their experiences; and all valued the rich resource of their bilingualism. Such reports again indicate the potential benefits of applying essentially positive psychology practices in order to cope with adverse experiences. Further research exploring how clinical psychologists cope with stressful, adverse experiences and any beneficial effects from strategies applied could yield insights that may be of use for professional development and wellbeing.

Implications for Clinical Practice

Collaborative Care

Both studies highlighted the importance and need for greater collaboration in healthcare and this imperative has relevance for practice (and policy) at all levels and across all

specialisms of clinical psychology. Integral to collaborative healthcare care is a whole-person approach to mental and physical healthcare, which necessitates an awareness of all factors impacting on an individual within their systems (Naylor et al., 2016). It involves families and others closely connected to the care-recipient as much as it requires collaborative working across services and disciplines, at all levels. There is increasing emphasis and evidence supporting collaborative care and many practitioners already engage in collaborative working across services with successful outcomes (Baxter et al., 2018).

With regard to young-carers, as advocated in the literature, providing them with adequate support can reduce burden of care and vulnerability to psychological problems. Clinical psychologists working directly with young people who are also carers or their adult care-recipients need to be aware of this phenomenon within their clients' ecological systems and its potential impact. This has obvious relevance for practitioners in child and adolescent mental health services (CAMHS). However, this critical background factor may not be revealed or evident in assessments and history taking, thus requiring highly attentive observation and sensitive inquiry within a strong therapeutic relationship. Beyond direct work, clinical psychologists can provide valuable leadership and consultation within MDTs and work collaboratively with school staff and counsellors to educate and raise awareness regarding the psychological impact of young-caring.

Awareness of young-carers also has relevance for clinical psychologists working with their care-recipients in clinical health psychology, adult mental health, and substance misuse services. When young-carers are unacknowledged or excluded from care and treatment planning, this can have an adverse impact on them as carers and omit information potentially critical to the effective treatment of their care-recipients. Unmet support needs and possible safeguarding issues could also be overlooked. Furthermore, many care-recipients with physical health problems develop mental health issues; and the increased vulnerability to mental illness among children whose parents have mental health or substance-misuse problems is well-established (Pakenham and Cox, 2014). When young people also take on carer responsibilities in these contexts, this can impact on their

psychological health and wellbeing. Practitioners in adult mental health and substance misuse services need to take account of this potential vulnerability and, if appropriate, collaborate with colleagues in CAMHS.

Linguistically and Culturally Sensitive Practice

Working collaboratively can also help ensure that care is linguistically and culturally sensitive, which is an imperative for all clinical and psychological practice. Failing to do so risks excluding groups within the population who may feel inhibited in accessing services perceived as inaccessible due to lack of cultural understanding or opportunity to communicate in their first/preferred language (Bauer et al., 2010). Findings from the empirical study highlighted the importance of being able to work in clients' language(s) of choice and respecting cultural and linguistic heritages. Although Welsh-speaking clinical psychologists are low in numbers, working across larger geographies within services is arguably more feasible since remote-working work with clients has become more common during the Covid-19 pandemic. Offering language choice to Welsh-speakers, whether they prefer to work entirely through the medium of Welsh, English or a blend of both, would be highly beneficial. It could enhance the psychological work, be more culturally sensitive and fulfil legal requirements. In services where systemic working is integral to the work with individual clients, this flexibility brings added value to clients' entire ecological system.

Cultural and linguistic awareness and sensitivity are essential qualities of clinical psychologists and should form part of ongoing professional development, supervision and reflective practice (Sue et al., 2009). Efforts to understand and respect clients' and colleagues' cultural heritage were evidently appreciated by study participants; and this undoubtedly supports effective team working and helps build positive working relationships. Educational sessions run by the local training programme were welcomed, especially for colleagues new to the area; and perhaps suggested websites and resources could be provided to supplement any such events in future. Understanding the cultural heritage of their client population will facilitate the psychological work and enhance the therapeutic relationship, which is critical to ensuring effective outcomes (Ardito &

Rabellino, 2011; Asnaani & Hofmann, 2012). Opportunities to learn Welsh are readily available but it is also worth noting that first-language Welsh speakers benefited from interventions to improve proficiency and increase confidence in formal communications, such as report or letter/email writing. Where services have been creative and supportive of Welsh-language learners and proficient speakers, tailoring their interventions accordingly, these have been welcomed and had a positive impact. Such initiatives are worth exploring and repeating across services.

Strength-based Focus

Many have called for clinical psychology to integrate evidence-based positive psychology interventions to rebalance the emphasis and focus on psychopathology and negative aspects of cognitive and behavioural functioning (Johnson & Wood, 2017; Seligman et al, 2006). In their seminal paper, Seligman and Csikszentmihalyi (2000) advocated the importance of promoting wellbeing as much as addressing mental illness, by supporting individuals to develop their psychological strengths and the capacity to access positive affect (Slade, 2010). The current separation of clinical and positive psychology is viewed as artificial; and integration would not only enhance research and clinical practice but also optimise intervention outcomes for individuals (Duckworth et al., 2005; Wood & Tarrier, 2010). Research indicates that positive psychology interventions are effective at reducing distress, improving interpersonal relationships and enhancing positive affect, all of which can buffer against stress and negative life-events (Carr et al., 2020). Positive affect has also been found to be effective in helping individuals to expand their problem-solving repertoires, also critical in reducing psychopathology (Fredrickson, 2004).

Both studies to varying degrees underlined the beneficial effects of building on strengths, reframing negative cognitive processes and focusing on positive emotional experiences such as finding meaning. Some young-carers were able to access positive emotional states when they perceived their caring-responsibilities as meaningful and purposeful; enjoy close relationships with care-recipients; build positive relationships with others; and value skills acquired as carers. These aspects are fundamentals of positive psychology which are often inextricably linked to therapeutic strategies that form part of evidence-based

interventions in clinical psychology. Cognitive-behavioural therapy (CBT) for example, encourages problem-solving, reframing of negative cognitions and replacing negative automatic thoughts with more rational, usually positive alternatives (Beck & Beck, 1995). Behavioural Activation involves engaging in activities, preferably meaningful ones, to reduce symptoms of depression. Third-wave CBT interventions such as ACT and DBT encourage commitment to values-based living and learning skills for more positive interactions with others.

Practitioners working with young-carers in mental health settings could consider focusing on developing skills and formulating strength-based goals alongside established interventions to reduce psychopathology symptoms. This is highly feasible where CAMHS services already use Goal-based Outcomes (Law & Jacob, 2015). Where young-carers do not meet criteria for CAMHS, due to age-limit or symptom severity, clinical psychologists could lead initiatives and provide consultation to colleagues in education, social care and third-sector organisations supporting young-carers. One example of such leadership and consultative working could be providing psycho-educational input to educators and support workers on how developing the strengths and skills young-carers acquire can buffer against stress.

Personal Reflections on the Research Process

Serendipity in Research

Deciding to explore the experiences of bilingual Welsh-English clinical psychologists practising in Wales and systematically review young-carers' experiences had a serendipitous dimension. Original proposed research fell by the wayside in the wake of the Covid-19 global pandemic. Although timescales were tight, sudden changes affecting everyone and the increasing focus on marginalised groups during the pandemic led to some reflections on personal and professional experiences during clinical training. In reflective practice with research supervisors, sharing experiences as a Welsh-speaking trainee clinical psychologist sparked a mutual interest. A brief search revealed that there had been no studies exploring the experiences of this particular group and thus research was warranted.

However, the dearth of research in general on bilingual psychological practice meant that a systematic literature review was not feasible. Challenges in finding a proposed review was compounded by discovering that reviews in related areas, such as culturally-modified therapeutic interventions, had recently been published. However, in the process of reflecting on how personally meaningful the empirical research question was for the lead-author, another serendipitous turn of events led to the literature review topic. Working with a vulnerable young-carer at the time piqued an earlier interest in young care-giving, having worked with and supported young-carers previously. Being a carer was also personally salient as the lead-author had been an informal carer in the past.

While researching the extant literature, it was evident that there had been growing interest in supporting young-carers. Since an earlier meta-ethnography over a decade ago, several subsequent studies had explored young-carers' experiences and therefore a literature review was deemed useful. However, despite increasing focus and support, this group of young people remain relatively hidden and often overlooked, in a similar vein to bilingual Welsh-English clinical psychologists. Thus a seemingly tenuous link between two very different groups became a thread clearly connecting this research project's two studies; and an illustration of how serendipitous the research process can be. Fine and Deegan (1996) defined serendipity in qualitative research as "the interactive outcome of unique and contingent 'mixes' of insight, coupled with chance" (p. 434). This aptly captures how the lead-author's personal reflections and chance discussion led to the final proposed research project. How the process of reflecting on practice with curiosity and interest can highlight a need for research is an experience that will stay with the lead-author as she continues to develop as a scientist-practitioner.

Researcher Vulnerability

There was awareness from the outset that there would be many commonalities between research participants and the lead-researcher as a Welsh-speaking trainee clinical psychologist. The concept of 'researcher as instrument' in qualitative studies (Patton, 2002) was uppermost in mind and reinforced the need for reflexivity to mitigate the impact of bias and subjectivity. During data-gathering, the extent to which the lead-author identified

with the participants in the empirical study soon became clear; and engaging in reflexivity and reflective practice discussions with supervisors were invaluable processes. However, at times when participants' experiences had been negative or resonated strongly, the lead-author was acutely aware of the emotional impact of undertaking this research project. Hearing about participants' negative experiences, especially of prejudice, disrespect and inequities had a profound effect and led to undertaking personal research into the concept of researcher vulnerability.

The research endeavour has rightly focused on protecting the researched, especially when power imbalances are heavily weighted towards researchers (Karnieli-Miller et al., 2009). Less so appears to have been investigated regarding researcher vulnerability beyond obvious examples relating to researcher personal safety in public health contexts. However, the potential for qualitative researchers to experience distress as a result of hearing about the adversities that others have experienced has been acknowledged (Bloor et al., 2008). A study involving professional researchers indicated that experiencing emotional distress, even among seasoned researchers, was not uncommon (Dickson-Swift et al., 2007).

Feelings of anger, dismay and sadness when hearing some participants' experiences and although indirect, reading analysed/secondary data regarding young-carers adverse experiences were not dissimilar to hearing about clients' difficult experiences on clinical placements. On reflection, things heard in clinical practice can be similar to what could constitute researcher vulnerability. Concurrent with this project was learning about moral injury (Shay, 2014) on clinical placement. Hearing about experiences and incidents that are injurious to moral codes and transgress personal values is a challenge in any context where another human being reveals difficult experiences. However, practices which support clinicians' self-care, such as reflective practice and taking challenging issues to supervision were as helpful during this research project as they are in clinical practice supervision. Many of the skills and self-care practices relevant to practising clinical psychologists have equal applicability to qualitative researchers exploring participants' lived experiences, especially where these are or have been adverse.

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Appendices

Appendix A: Data Extraction Template

Appendix B: CASP Quality Appraisal Template

Appendix C: Bilingual Participant Information Sheets

Appendix D: Bilingual Participants Informed Consent Forms

Appendix E: Six-phase framework & 15-point checklist for Thematic Analysis

Appendix F: Translated Participant Transcript Extract with Initial Coding

Appendix G: Research Protocol

Appendix A: Data Extraction Template

Data extraction field	Information extracted
<p>Context and participants</p> <p>Aim/RQ</p>	<p><i>Study setting, participants, the intervention delivered etc. Referral back to the original papers alongside extracted data during the analysis process.</i></p> <p><i>Study aim/RQ</i></p>
<p>Study design and methods used</p>	<p><i>Methodological approach taken by the study; the specific data collection and analysis methods utilized; and any theoretical models used to interpret or contextualize the findings. The data extraction approach, and therefore the data extraction template, may need to be flexible so as to accommodate data collected within different qualitative methodologies (ethnography, phenomenology etc.) and using different methods (interview, focus groups, observations, document analysis etc.).</i></p>
<p>Findings</p>	<p><i>Covers key themes or concepts identified in the primary studies. (Also NB conclusions/discussions).</i></p>
<p>Quality of the study</p>	<p><i>CASP</i></p>

Adapted from: Noyes & Lewin (2011)

Appendix B: CASP Quality Appraisal Template

CASP

A: Are results valid?	Yes	No	Can't tell
1. Was there a clear statement of the aims of the research?			
2. Is a qualitative methodology appropriate?			
3. Was the research design appropriate to address the aims of the research?			
4. Was the recruitment strategy appropriate to the aims of the research?			
5. Was the data collected in a way that addressed the research issue?			
6. Has the relationship between researcher and participants been adequately considered?			
B: Results			
7. Have ethical issues been taken into consideration?			
8. Was the data analysis sufficiently rigorous?			
9. Is there a clear statement of findings?			
C: Will the results help locally?			
10. How valuable is the research?			

Appendix C: Bilingual Participant Information

Participant Briefing Letter



NWCPP-RSCGC
Brigantia Building
Bangor University
Bangor
Gwynedd
LL57 2DG

Date

Dear

As part of my Doctorate in Clinical Psychology at Bangor University, I am conducting research into the experiences of Welsh speaking Clinical Psychologists who are practising in Wales.

For this study, I will be interviewing a small number of Welsh first-language, practising Clinical Psychologists to find out more about what their experience of being a bilingual clinician have been. As someone who meets the participant inclusion criteria, I would like to invite you to participate in this study. The enclosed information sheet provides further detail on what being a participant will involve.

If you do decide to participate but change your mind at a later stage, you are free to withdraw at any time from all or part of the study and your decision will be accepted without question. Your participation in the project will be confidential and your identity would be anonymised. Interviews will take place at a time to suit you.

If you are interested in participating in the study or would like to discuss this further before deciding, please do not hesitate to contact me.

Yours sincerely,

Eleri Griffith
Email: pep01a@bangor.ac.uk
Phone: 01248 382205



Information for Prospective Study Participants

Study Title: *'Working as a Welsh-English Bilingual Clinical Psychologist: a Qualitative Study'*.

Researcher: Eleri Griffith, Trainee Clinical Psychologist, NWCPP.

- The aim of the proposed study is to explore the experiences of practising clinical psychologists who are bilingual, first language Welsh speakers. The study will involve interviewing a small number of participants on an individual basis on one occasion to find out more about what their experiences have been and what these have meant for them. A small value gift token will be offered in appreciation of participants' time and contribution to the study.
- Interviews will take place at time to suit you. In view of the current pandemic, interviews will be conducted over the phone or via video conferencing. Both participants and researcher will need to be in a private room during the interview to preserve confidentiality. Interviews will last no longer than 90-120 minutes but you are free to end the interview sooner if you so choose.
- During the interview you will be asked to share your experiences and thoughts as openly as possible. I will only be asking a few questions and there are no 'right' answers. Interviews can be conducted in Welsh or English depending on participant preference. When the interviews have been completed, I can tell you a bit more about the rationale behind this study if you so wish.
- Interviews will be audio recorded and transcribed immediately afterwards. The use of audio recording will help to capture everything that is said without the distraction of extensive note taking. Recordings will be stored in password protected audio files accessible only to the researcher. Recordings will be deleted once each interview has been transcribed.
- The information you share and your identity will be anonymised throughout this study with the use of pseudonyms. This means that there will be no reference to your name or any other personal details that would enable anyone to identify you, either in the transcription or the project report presented to the university.
- Participants' names and identities will be known only to the researcher and the list of first names only and ascribed pseudonyms will be stored electronically in a password protected document on a computer which is not shared and has password protected access.
- Audio files and electronic copies of transcribed data will be stored on a password protected computer stored in a locked room. All hard copies of documents containing data from the

study and handwritten notes from the sessions will be stored in a lockable cupboard. At the end of the study, all documentation will be archived securely and confidentially destroyed as soon as the qualification has been awarded.

- Protecting research participants from harm is paramount and ensuring your participation is confidential is a critical aspect of this. However, while your participation in the study will be kept confidential, should you disclose any serious risk of harm to yourself or anyone else, then the confidentiality agreement would have to be broken and what that would involve would be explained as appropriate.
- Please note that your participation in this research project is voluntary. You will be free to withdraw at any time from the study and there would be no need to offer an explanation. You would also be able to withdraw your consent after the interview has been conducted and any data collected from you will be removed from the study and confidentially destroyed immediately.
- Before the interview, you will be asked to read and sign what is known as an informed consent form, which is enclosed, just for information at this stage. This is to confirm that you have understood the information provided, how your participation will be kept confidential and that you have the right to withdraw from the study at any point.
- If you have any queries or concerns about the way in which the research is conducted, in addition to raising these with me, you can also contact either one of the supervisors for this study. Their contact details are provided below.
- If you have any questions or would like to discuss anything in the meantime, please feel free to contact me.

Thank you.

Eleri Griffith
Email: pep01a@bangor.ac.uk
Tel: 01248 382205

Research Supervisors:

Dr Mike Jackson, NWCPP
mike.jackson@bangor.ac.uk
01248 388746

Dr Chris Saville, NWCPP
c.saville@bangor.ac.uk
01248 388740

Address for both supervisors:
NWCPP-RSCGC
Adeilad Brigantia, Prifysgol Bangor
Bangor, Gwynedd. LL57 2DG

Llythyr Gwybodaeth i Gyfranogwyr



NWCPP-RSCGC
Adeilad Brigantia
Prifysgol Bangor
Bangor
Gwynedd
LL57 2DG

Dyddiad

Annwyl

Fel rhan of fy nghwrs Doethuriaeth mewn Seicoleg Clinigol rwyf yn ymchwilio profiadau Seicolegwyr Clinigol Cymraeg iaith gyntaf sydd yn gweithio yng Nghymru.

Byddaf yn cyfweled â nifer bychan o Seicolegwyr Clinigol i ddarganfod a thrafod eu profiadau o weithio fel clinigwyr dwyieithog. Fel rhywun sydd yn cwrdd a'r meini prawf, hoffwn eich gwahodd i gymryd rhan yn yr ymchwil yma. Amgaeaf daflen wybodaeth sydd yn cynnwys mwy o fanylion am yr astudiaeth.

Os ydych yn dewis cymryd rhan ond yn newid eich meddwl yn hwyrach ymlaen, rydych yn rhydd i dynnu nol ac ni fydd angen esboniad. Bydd eich cyfraniad yn gwbl gyfrinachol. Ni fydd modd eich adnabod a byddaf yn defnyddio ffug enwau yn yr adroddiad. Cynhelir cyfweiliadau ar amser cyfleus i chi.

Os hoffech gymryd rhan yn yr ymchwil ac/neu am fwy o wybodaeth, gadwech i mi wybod ac fe gawn drafodaeth bellach.

Yn gywir,

Eleri Griffith
Ebostl: pep01a@bangor.ac.uk
Ffôn: 01248 382205



Gwybodaeth am yr Astudiaeth i Ddarpar Gyfranogwyr

Teitl: *'Gweithio fel Seicolegydd Clinigol Dwyieithog, Cymraeg Iaith Gyntaf: Astudiaeth Ansoddol'*.

Ymchwilydd: Eleri Griffith, Seicolegydd Clinigol dan Hyfforddiant, RSCGC.

- Bwriad a nôd yr astudiaeth arfaethedig yma yw i archwilio profiadau seicolegwyr Cymraeg iaith gyntaf. Byddaf yn cyfweld yn unigol â nifer bach o gyfranogwyr ar un achlysur i ddarganfod eu profiadau a beth mae rhain yn eu golygu iddynt. Cynnigir tocyn rhodd bychan i ddiolch am y cyfraniad a'r amser a roddir gan gyfranogwyr i'r ymchwil.
- Cynhelir y cyfweiliadau ar adeg cyfleus i'r cyfranogwyr. Oherwydd y pandemig cyfredol, dros y ffôn neu ar alwad fideo y cynhelir y cyfweiliadau. Bydd angen i gyfranogwyr hefyd fod mewn ystafell breifat er mwyn cyfrinachedd yn ystod y cyfweiliad. Gall y cyfweiliad gymryd tua 90-120 munud ond dim hirach a gallwch ddod a'r cyfweiliad i derfyn yn gynt os hoffech neu bydd angen.
- Yn ystod y cyfweiliad, byddaf yn gofyn i chi rannu eich profiadau. Ni fydd llith o gwestiynnau ac nid oes ateb 'cywir' na delfrydol. Gewch ddewis i gynnal y cyfweiliadau drwy gyfrwng y Gymraeg neu Saesneg, yn ôl eich dymuniad. Ar derfyn y cyfweiliad, gallaf rannu mwy o wybodaeth am y rhesymeg tu ôl i'r astudiaeth os hoffech wybod mwy am hyn.
- Bydd y cyfweiliadau yn cael eu recordio ac yna eu trawsgrifio yn syth bin ar ôl y cyfweiliad. Bydd hyn yn helpu i sicrhau fod yr hyn oll sydd yn cael ei ddweud yn cael ei gofnodi heb orfod ysgrifennu nodiadau yn ystod y cyfweiliad. Caiff y recordiau eu cadw yn ddiogel ar ffeil electroneg sydd angen cyfrinair i'w agor fydd yn hysbys i'r ymchwilydd yn unig. Caiff y recordiau yn cael eu dileu gynta bydd y trawsgrifio wedi ei gwblhau.
- Defnyddir ffug enwau i sicrhau na fydd modd i neb ddarganfod pwy gyfranodd ac ni ddefnyddir unrhyw wybodaeth â all arwain at unrhyw gyfranogwr yn cael ei adnabod. Ni chaiff enwau na manylion personol eu defnyddio yn y trawsgrifiadau na'r adroddiad gaiff ei gyflwyno i'r brifysgol ar derfyn yr astudiaeth.
- Dim ond yr ymchwilydd fydd yn gwybod pwy fydd wedi cyfrannu a dim on cyfeiriadau ebost, enw a rhif cyswllt fyd yn cael eu cadw ar restr sydd angen cyfrinair ar gyfrifiadur dan glo. Bydd angen cyfrinair i gael mynediad at bob ffeil electroneg ac mi fydd pob darn o babur yn cael eu cadw dan glo.

- Ar ddiwedd yr astudiaeth bydd pob dogfen bapur a ffeil electroneg yn cael eu dileu yn ddiogel cyn gynted ac y bydd y cymhwyster wedi ei gadarnhau.
- Mae cadw gwybodaeth ac enwau cyfraogwyr yn gyfrinachol yn holl bwysig ac yn blaenoriaethu. Er nad yw hyn yn debygol, petae unrhyw gyfranogwr yn dategelu unrhyw risg, mi fydd angen trafod hyn a gall hyn arwain at dorri cyfrinachedd er mwyn diogelwch.
- Bydd unrhyw gyfraniad yn hollol wirfoddol ac mi fydd gan pawb sydd yn cymryd rhan hawl i dynnu nol o'r ymchwil heb angen eglurhad, hyd yn oed ar ôl y cyfweiliad ac mi fydd y data a gasglwyd ganddynt yn cael ei ddileu.
- Cyn y cyfweiliad, gofynnir i bawb sydd am gyfrannu ddarllen ac arwyddo ffurflen caniatâd i ymchwilio. Amgaeaf gopi er gwybodaeth. Bwriad hyn yw i gadarnhau eich bod wedi derbyn ac yn deall y gwybodaeth am yr hyn a ddisgwylir gan gyfranogwyr, trefniadau i sicrhau cyfrinachedd a diogelwch ac fod hawl gennych i dynnu nol o'r ymchwil unrhyw dro.
- Os bydd unrhyw gwestiwn neu gonsyrn am y modd y cynhelir yr astudiaeth, yn ogystal a'u codi efo'r ymchwilydd bydd hefyd modd cysylltu unrhyw un o'r ddau oruwchwylywr. Ceir eu manylion cyswllt islaw.
- Os oes gennych unrhyw gwestiwn cyn penderfyni os am gymryd rhan, mae croeso i chi gysylltu a mi er mwyn cael agwrs anfurfiol.

Diolch yn fawr.

Eleri Griffith
 Ebost: pep01a@bangor.ac.uk
 Ffôn: 01248 382205

Goruwchwylywr Ymchwil:

Dr Mike Jackson
mike.jackson@bangor.ac.uk
 01248 388746
 Cyfeiriad post i'r ddau oruwchwylywr:
 NWCPP-RSCGC, Adeilad Brigantia
 Prifysgol Bangor,
 Bangor, Gwynedd.
 LL57 2DG.

Dr Chris Saville
c.saville@bangor.ac.uk
 01248 388740

Appendix D: Participant Informed Consent Forms



NWCPP - RSCGC

Participant Informed Consent Form



Project Title: *'Working as a Welsh-English Bilingual Clinical Psychologist: a Qualitative Study'*. **Researcher:** Eleri Griffith

I, the undersigned, confirm that (please initial each box as appropriate):

1.	I have read and understood the information about the project, as provided within the letter and information document from the researcher dated _____.	
2.	I have been given the opportunity to ask questions about the study and what my participation would involve.	
3.	I voluntarily agree to participate in the project and understand that I will receive a small gift-token in appreciation of my time and participation.	
4.	I understand that I can withdraw at any time without any need to provide reasons and that I will not be questioned on why I have withdrawn or be persuaded not to withdraw.	
5.	The procedures regarding confidentiality have been clearly explained to me (e.g. use of names, pseudonyms, anonymised data, etc.).	
6.	The use of audio recording for data collection has been explained to me.	
7.	The use of the data gathered in the research, its storage and arrangements for its secure disposal at the end of the study have been explained to me.	
8.	I understand that this supervised study will be undertaken by one main researcher and that no other researchers will have access to the data.	
9.	I, along with the Researcher, agree to sign and date this informed consent form.	

Participant

Name:

Date:

Signature:.....

Researcher:

Name:

Date:

Signature:.....



NWCPP - RSCGC



Ffurflen Caniatâd i Ymchwilio gan Gyfranogwyr

Teitl y Prosiect: 'Gweithio fel Seicolegydd Clinigol Dwyieithog, Cymraeg Iaith Gyntaf: Astudiaeth Ansoddol'. Ymchwilydd: Eleri Griffith

Rwyf i, sydd wedi arwyddo isod, yn cadarnhau (nodwch llythrennau cyntaf eich henw ogyd):

1.	Mod i wedi darllen ac yn deall y wybodaeth ynglyn a'r ymchwil yn y llythyr a'r daflen wybodaeth a dderbynwyd gan yr ymchwilydd ar (dyddiad):_____.	
2.	Cefais gyfle i ofyn cwestiynnau am yr astudiaeth a beth mae'n olygu i gyfranogwyr.	
3.	Rwyf yn cytuno i gyfrannu yn wirfoddol i'r ymchwill a deallaf y byddaf yn derbyn tocyn rhodd bychan i ddiolch am y cyfraniad a'r amser a roddwyd i'r ymchwil.	
4.	Deallaf y câf dynnu nol o gyfrannu unrhyw dro ac ni fydd angen eglurhad na neb yn rhoi pwysau arnai i barhau fel cyfranogwr.	
5.	Cafodd y trefniadau i sicrhau cyfrinachedd eu hegluro yn glir i mi (e.e. ffug enwau, trefniadau gwarchod data ayb).	
6.	Cefais eglurhad am pam a sut y bydd y recordiau sain yn cael eu defnyddio.	
7.	Cefais eglurhad am sut y caiff y data a gesglir yn ystod yr ymchwil ei ddefnyddio, ei gadw a'i ddileu yn ddiogel ac yn gyfrinachol.	
8.	Deallaf mai dim ond un ymchwilydd fydd yn cynnal yr ymchwil ac ni fydd ymchwilwyr eraill yn cael mynediad i'r data.	
9.	Rwyf fi a'r ymchwilydd yn cytuno i arwyddo a nodi dyddiad ar y ffurflen ganiatâd.	

Cyfranogwr:

Enw:

Dyddiad:

Llofnod:.....

Ymchwilydd:

Enw:

Dyddiad:

Llofnod:.....

Appendix E: Six-phase framework & 15-point checklist for Thematic Analysis

Six-Step Framework

Step 1: Become familiar with the data	Step 4: Review themes
Step 2: Generate initial codes	Step 5: Define themes
Step 3: Search for themes	Step 6: Write-up

15-point checklist for good TA

Transcription

1. The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.

Coding

2. Each data item has been given equal attention in the coding process.
3. Themes have not been generated from a few vivid examples (anecdotal approach) but, instead, the coding process has been thorough, inclusive and comprehensive.
4. All relevant extracts for all each theme have been collated
5. Themes have been checked against each other and back to the original data set.
6. Themes are internally coherent, consistent, and distinctive.

Analysis

7. Data have been analysed rather than just paraphrased or described.
8. Analysis and data match each other – the extracts illustrate the analytic claims.
9. Analysis tells a convincing and well-organised story about the data and topic.
10. A good balance between analytic narrative and illustrative extracts is provided.

Overall

11. Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.

Written report

12. The assumptions about TA are clearly explicated.
13. There is a good fit between what you claim you do, and what you show you have done – ie, described method and reported analysis are consistent.
14. The language and concepts used in the report are consistent with the epistemological position of the analysis.
15. The researcher is positioned as active in the research process; themes do not just 'emerge'.

Braun & Clarke (2006)

Appendix F: Translated Participant Transcript Extract with Initial Coding

<p>P I really only had one interview, ever, where somebody even asked me a question in Welsh! I suppose maybe that was to make sure I really could speak Welsh! (laughs)...and that was fine...yeah so thinking about this when I was on the course and training, umm there was no opportunity to learn and discuss things in Welsh...and nobody else in my cohort could speak Welsh and none of the teaching was done in Welsh...but I think that changed a bit after I qualified It seems like they were really trying to get a bit more Welsh into the programme. But I was just really pleased that I was able to work in this area and use my ability to speak Welsh and know that it could help, could really help a lot of people because you know yourself you know, when you have to go see a doctor or something and maybe you have something big or difficult to say and you find yourself thinking I hope he or she can speak Welsh maybe don't you? Cos sometimes it's a lot easier so much easier to explain things in your own language in your first language isn't it? So yes I was really pleased that I was able to do that...</p> <p>.....</p>	<p>Interviews in English – minimal focus on Welsh</p> <p>Training mainly English medium Only Welsh-speaker in cohort</p> <p>Changing - more awareness/focus on Welsh lang on training</p> <p>Pleased able to use skills able to help those in need of welsh medium service – sees need. Empathy for ptx when seeing clinicians and smthing difficult to say easier in L1 than L2</p> <p>Relating to ptx relief</p>
<p>P: yes...and of course I'm now in a team where most people, if not everybody speaks Welsh, which is quite nice actually...yeah...umm (pause/reflecting)...yes...I think being a supervisor I'm able to offer supervision in Welsh and placements that are Welsh...yeah (pause/reflects)...do you know what I've never thought that I've got a really/particularly special skill, you know, I've never really thought about that really, that I'm able to offer a placement and supervision in Welsh and maybe there's not a lot of people who can do that, you know able to offer a placement where they [trainees] can get experience of being with a team where nearly everybody can speak Welsh, work with clients who</p>	<p>Welsh spkn wrk context – team all spk welsh</p> <p>Supervises bilingually – pride able to offer supn in welsh Welsh lang ability not prev. considered seen special skill</p> <p>Reflecting on what able to offer trainees – entirely Welsh plcmnt. Supervision, MDT, clin. wrk etc</p> <p>Rare/ unique expernce but felt natural tho onlookers</p>

<p>are Welsh speaking and then also have their supervision in Welsh. Because to me that's natural but maybe for somebody else, looking in from the outside, they would think oh it's not often...or in many places that that could be offered and I suppose I've never really thought about it like that and so yes any Welsh speakers coming on placement with me that's what they get, that experience of speaking Welsh with a team and with clients. But of course anyone that comes here who can't speak Welsh and coming into a Welsh speaking team, they probably wouldn't have been used to that so I have to make a point of discussing that at the beginning with new trainees who can't speak Welsh, explain to them if they are not used to it, help them understand, that this is what happens and occurs naturally, you know, nobody's talking about you or anything like that....</p> <p>.....</p>	<p>would see how it's different –P hadn't really thought about it previously</p> <p>Aware this could be difficult/strange for non-Welsh spkrs.</p> <p>Explains & prepares them - this is norm/naturally occurring. Nothing personal /insidious.</p> <p>Need to explain, avoid any awkwardness</p>
<p>P: So yes well and when it comes to working with clients well as you can hear from talking to me now I use/throw in English words when I speak Welsh and so for example when I'm using CBT I've never looked up what CBT is in Welsh...so...yeah you know but you've got some who will make sure they are using absolutely the correct words and terminology in Welsh...but I've never done that I have to admit But then you know I also think if you're working with someone and they've never heard of CBT and terms like that at least at least if you use terms like CBT then they can at least go and look it up Google it or something you know but if I use the Welsh terms for things like that they wouldn't be able to look go and look it up for themselves and things like that you know And it's never been a problem Yeah but you know the one thing I do sometimes feel that I don't do well/properly is that I don't use the correct terminology in Welsh...these terms do sound so much more natural somehow in English don't they because you've heard them</p>	<p>Uses Eng terms/ words when speaking Welsh</p> <p>Doesn't bother finding out what terms like cbt are in Welsh Acknowledges some learn terminology</p> <p>English psych terms more familiar and accessible Easier for ptx to search Eng terms</p> <p>Use of English terms ok tho' some</p> <p>Some discomfort re not using correct Welsh terms</p>

<p>all before already and they are more familiar you'll hear it all around you. And that's really how I went through the whole program I haven't heard these terms in Welsh so when I was learning about CBT it was CBT that I was hearing every day so those are the words I'm used to the terms that I learnt...and the words I still use. But if you spoke to other people they'd probably say 'no I actually use the terms the proper terms in Welsh. And so yes when you do come across people who's Welsh is really good so much better than yours or seems that way it does make you feel www sometimes, yeah...and you find yourself racking your brains what is that the right term in Welsh and so yes that can knock your confidence a little bit you know...make you feel a little bit hmmm...</p> <p>.....</p> <p>P Yeah...and so that can be kind of a little battle within you really in that moment when you realise 'oh gosh this person's Welsh is so much better than mine And then if I'm using English words find myself wondering will they get a bit cross/irritated, especially if somebody, a client has specifically asked if they could work or have somebody who is a Welsh speaker And then I turn up And maybe my Welsh isn't good enough So yes you have to fight against that a little bit at the start internally until you can then start relaxing and you realise that actually people will accept how you speak... your standard of Welsh and really if they want to correct you, they will correct you And that's ok (laughs) but then I have to make sure I remember what they have corrected and h the correct term is for next time (laughs) but you know I reckon it's you that feels that more than they do, anyway I think it's just you that's thinking about how their Welsh is so much better than mine, they are much better than me...and I'm the doctor supposedly (laughs)</p> <p>.....</p>	<p>Familiar with terms in Eng. Feel more natural & used more.</p> <p>Learned psych terms in Eng – trained in Eng so psych terms etc more used & familiar in Eng lang.</p> <p>Tho' acknowledges others use Welsh terms</p> <p>Feels awkward when when interacting with others with better Welsh</p> <p>Struggle to find correct Welsh words-affects confidence. Discomfort</p> <p>Internal tension/conflict Fear that if person has 'better' might be displeased esp if ptx asked for Welsh speaker – assumes will be judged/seen negatively.</p> <p>Fears that Welsh not good enough but acknowledged internal conflict. But once meet with ptx can relax – fears reframed</p> <p>Acceptance</p> <p>Humour Recognises negative thinking are own assumptions own self-talk She's the doc so more intelligent - humour</p>
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<p>P: It's perhaps a bit easier to make a connection when I'm working with clients To make that connection build that relationship a bit more quickly maybe when you have a connection because you share the same Language you know So it's like when people realise you can speak Welsh they think or you're part of my area the same environment you come from the similar area to me So you can understand, understand them better because you've grown up In a similar area kind of thing because you know there is something about Welsh people they like to know where you're from And how do you you fit in around here then and a course if you speak Welsh that's done that bit for you Kinda thing If that makes sense..</p> <p>Yeah you know it's like they then realise or think or expect that you've lived the similar had of Life to them and that happens quite quickly...</p> <p>yeah they expect you've lived a similar life to then don't they And maybe you haven't at all all you know Somehow you don't have to persuade them that you don't understand them and the environment that they've grown up in or live then because you come from the similar environment So you will understand them better...but that can be a problem sometimes too to that the assumption that you know we all like eisteddfod and I really don't like eisteddfod but then I'll go and see clients And they'll be asking me you're talking about a eisteddfod (laughs) So that could be a problem you know because people just wouldn't understand that laughs But I suppose at least it means I know what it is and I can understand that (part of the culture)</p> <p>feels totally natural...in a way It's maybe a bit easier because you don't have that battle that effort to find the right word I've got to think of the right word To use and you're used to having used these words in English You've had more practice in it [working in English] really</p>	<p>Able to speak Welsh facilitates connection with client – shared experiences & cultural contexts</p> <p>Being welsh/welsh spkr used as heuristic – can understand me/issues/my bckgrnd easier better</p> <p>Can lead to overfamiliarity/boundaries – if welsh want to know who u r/where frm etc</p> <p>Able to identify – social identification</p> <p>Facilitates rapport & estab of realstshp</p> <p>Know u undrstnd them, ease</p> <p>Assumptns have siml life contexts</p> <p>as pt will feel you understand them – you come from same environ as me so no need to persuade you can understand me as ur pt [Power more balanced?]</p> <p>assumptns can be problematic if you don't share same ints</p> <p>bt at least you have some knowl/awareness of what that is</p> <p>working in Eng can be easier in some ways cos doesn't distract/impact on confidence</p>
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Appendix G: Research Protocol

IRAS Research Protocol

This protocol has regard for the HRA guidance and order of content

FULL/LONG TITLE OF THE STUDY

'Working as a Welsh-English Bilingual Clinical Psychologist: a Qualitative Study'

SHORT STUDY TITLE / ACRONYM

Experiences of working as a Welsh first language clinical psychologist

PROTOCOL VERSION NUMBER AND DATE:

Draft version 0.1 Date: 30.06.2020

RESEARCH REFERENCE NUMBERS


IRAS Number:	285432
SPONSORS Number:	2020-16771
FUNDERS Number:	n/a

SIGNATURE PAGE

The undersigned confirm that the following protocol has been agreed and accepted and that the Chief Investigator agrees to conduct the study in compliance with the approved protocol and will adhere to the principles outlined in the Declaration of Helsinki, the Sponsor's SOPs, and other regulatory requirement.

I agree to ensure that the confidential information contained in this document will not be used for any other purpose other than the evaluation or conduct of the investigation without the prior written consent of the Sponsor

I also confirm that I will make the findings of the study publicly available through publication or other dissemination tools without any unnecessary delay and that an honest accurate and transparent account of the study will be given; and that any discrepancies from the study as planned in this protocol will be explained.

For and on behalf of the Study Sponsor:		
Signature: C. E. Griffith		Date: 02/07/2020
Name (please print): Dr Catherine Eleri Griffith		
Position: Principal Investigator and Doctoral Student (Trainee Clinical Psychologist), NWCPP, Bangor University		
Chief Investigator:		
Signature: 		Date: 02/07/2020
Name: (please print): Dr Mike Jackson		

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KEY STUDY CONTACTS

Chief Investigator	Dr Mike Jackson mike.jackson@bangor.ac.uk 01248 388746
Study Co-ordinator	Dr Catherine Eleri Griffith pep01a@bangor.ac.uk 01248 382205
Sponsor	Mr Huw Ellis College Manager, College of Human Sciences Bangor University huw.ellis@bangor.ac.uk 01248 383229
Joint-sponsor(s)/co-sponsor(s)	n/a
Funder(s)	n/a
Key Protocol Contributors	n/a
Committees	n/a

STUDY SUMMARY

Study Title	Working as a bilingual, Welsh first-language clinical psychologist: a Qualitative Study
Internal ref. no. (or short title)	
Study Design	Qualitative
Study Participants	Qualified clinical psychologists whose first language is Welsh
Planned Size of Sample (if applicable)	8 approx.
Follow up duration (if applicable)	n/a
Planned Study Period	10 months
Research Question/Aim(s)	“How have Welsh speaking clinical psychologists experienced professional training and practice?.

FUNDING AND SUPPORT IN KIND

FUNDER(S) (Names and contact details of ALL organisations providing funding and/or support in kind for this study)	FINANCIAL AND NON FINANCIAL SUPPORT GIVEN

ROLE OF STUDY SPONSOR AND FUNDER

This study is sponsored by Bangor University. The manager of the University's College of Human Sciences is the Sponsor representative. This study is in part fulfilment of the qualification of Doctorate in Clinical Psychology awarded by the North Wales Clinical Psychology Programme (NWCPP), School of Psychology, Bangor University. The proposed study has been reviewed and approved by the School of Psychology's Ethics Committee and as such the University as Sponsor will oversee the ethical and professional conduct of the research. The study will be supervised by two experienced academic researchers, one of whom is the CI. Study design, conduct, data analysis and interpretation, report/manuscript writing, and dissemination of results will be the sole responsibility of the CI, PI and supervisor and be independent of the sponsor's representative. They, along with the PI, will ensure the research is undertaken rigorously, ethically and confidentially.

ROLES AND RESPONSIBILITIES OF STUDY MANAGEMENT COMMITTEES/GROUPS & INDIVIDUALS

n/a

PROTOCOL CONTRIBUTORS

Protocol author: Dr Catherine Eleri Griffith

Approved by: Dr Mike Jackson & Dr Chris Saville

Ethical approval granted by: Ethics Committee, School Psychology, Bangor University

KEY WORDS:	Bilingual, Welsh-speaking, clinical psychology, clinical psychologists.
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STUDY FLOW CHART

Once R&D approval has been obtained, the study's timeline of activity will be:

July/August 2020	<i>Revise and resubmit IRAS application if necessary</i>
Sept/Oct 2020	<i>Participant recruitment and data-gathering</i>
Oct 2020 to Jan 2021	Conduct interviews; transcribe data; begin data analysis
January to March 2021	Data analysis
March/April 2021	Write up data analysis/draft report
May 2021	Write up full empirical report and submit for assessment
June 2021	Viva

RESEARCH PROTOCOL

STUDY TITLE:

'Working as a Welsh-English Bilingual Clinical Psychologist: a Qualitative Study'

1. BACKGROUND

1.1 Introduction

Bilingualism is defined as the ability to speak two languages with equal or near equal fluency. However, equal proficiency can vary substantially and most bilingual people (BP) learn languages in different contexts and not always simultaneously (Castaño et al., 2007). Many BP are 'subordinate' bilinguals whose first language (L1) routinely dominates daily life and discourse (Sciarra & Ponterotto, 1991). Furthermore, languages are not totally interchangeable and some words and concepts are beyond translation: even fluent BP cannot always provide an exact translation of their internal narrative (Panayiotou, 2004). For many BP, L1 is their language of 'emotional expressiveness' (Burck, 2004) while their second language (L2) is often associated with emotional distancing (Dewaele, 2004; Sutton et al., 2007). Amati-Mehler et al. (1991) purported that L1 is also the medium by which speech patterns and cognitive processes are initially developed.

Research into bilingualism and psychological therapy is limited and predominantly focused on Hispanic therapy clients/patients in the US. These studies typically involve surveys or small-scale, often single-case studies undertaken within psychotherapy and through the theoretical lens of psychoanalytical and cognitive psychology. There has been some, limited research into the experiences of bilingual therapist/practitioners, again predominantly in North America. Some postgraduate dissertations have explored the experiences of Welsh speaking counsellors but research involving Welsh speaking clinical psychologists appears to be non-existent.

1.2 Psychological Aspects of Bilingualism in Therapeutic Contexts

Overall, studies have found that BP prefer to communicate feelings and internal processes using L1 as this is also typically the language of their inner dialogue (Pavlenko, 2005; Dewaele, 2008, 2011, 2013). Findings indicate that internal experiences expressed in L1 are

communicated more candidly and authentically; and clients feel less constrained by the cognitive process of searching for appropriate words (Burck, 2004; Byford, 2015; Softas-Nall et al., 2015). Intimate details of past experiences can have different meanings and/or associations in each language for BP, who have been found to switch languages to describe difficult experiences (Kokaliari et al., 2013).

It has been suggested that the language used most frequently in the home is more likely to be the language in which BP feel most comfortable describing emotionally difficult experiences (Biever et al., 2002; Burck, 2011; Collado et al., 2016). However, Costa (2010) found that some BP preferred to use L2, especially if learned after formative years, to express something that may have been considered taboo within their childhood/native language and culture. Imberti (2007) similarly posits that a BP's second language may be used as coping mechanism when relating difficult experiences or expressing emotions that may have been censored or restricted by others. Costa (2010) purports that when BP have experienced and encoded a trauma in L1, recalling and relating it in L2 serves as protection from traumatic memories. The use of a later learned language in therapy by clients has been described as a 'distancing strategy' to avoid painful events experienced in L1 (Dewaele, 2010; Pérez-Foster, 1998)

Language for BP is thus seen as having a 'dual function' of protection against emotional pain and enabling unfettered expression to facilitate therapeutic change (Foster, 1996). Participants surveyed by Dewaele and Costa (2013) reported using language switching both to access and distance themselves from experiences; with some describing this capacity to manage their 'emotional flow' as highly empowering. Tehrani and Vaughan (2009) also concluded that language switching by BP provided an opportunity to develop 'emotional mastery', as problems explored in a different language can bring new perspectives. Imberti (2007) similarly concluded that language switching to find more appropriate words to express difficult emotions enhanced emotional self-regulation.

According to Costa (2014) identity is a function of language preference/choice and BP can present different parts of their selves during therapy, depending on the language used (Dewaele, 2015; Pavelnko, 2005). Bilingualism is an important aspect of many BP's self-

concept as they experience the world in different ways, developing schemas according to the language used in differing contexts (Foster, 1996; Dewaele & Costa, 2013). In a study involving over 1000 BP, over two-thirds of respondents reported sometimes feeling like a different person depending on language used (Pavlenko, 2006). In several other studies, participants, including proficient BP, felt different when using L2, with some reporting feeling more ‘fake’ or inauthentic when speaking languages other than L1 (Dewaele, 2015; Dewaele & Nakano, 2013; Ozańska-Ponikwia, 2012).

1.3 Bilingualism & Therapeutic Practitioners

The effectiveness of psychological therapy has been found to be associated with understanding as a result of language proficiency, which has profound implications for practitioners (Bradford and Muñoz, 1993; Burck, 2011; Hansen et al., 2000; Kissil et al., 2013; Musser-Granski & Carrillo, 1997; Peters et al., 2014; Torres et al., 2017; Van Loon et al., 2013; Woidneck et al., 2012). Costa (2010) reported that bilingual therapists’ frequently used their bilingualism to support BP with finding appropriate words and/or phrases to capture their emotional experiencing and enhance understanding. When a therapist can speak the client’s L1 and has a shared cultural background, this has been found to have a positive impact on the therapeutic relationship and process (Ramos-Sánchez et al., 1999; Santiago-Rivera et al., 2009; Verdinelli & Biever, 2009). Some have highlighted, however, that shared a language and culture can lead to over-identification and/or collusion between therapist and clients, who may also find such commonalities inhibiting (Altarriba & Santiago-Rivera, 1994; Dewaele & Costa, 2013; Nguyen, 2014). Nevertheless, being able to work psychologically in clients’ preferred, usually L1, has been shown to facilitate their capacity to reframe cognitions, develop coping strategies and build resilience (Burck, 2011; Kirmayer, 2012; Van Loon et al., 2013; Woidneck et al., 2012).

Conversely, when having to use L2 during therapy, some BP report feeling detached from their thoughts, feelings and experiences, which can hinder progress and therapeutic change (Softas-Nall et al., 2015; Torres et al., 2017). Focusing on the language used to describe thoughts, emotions and behaviours can distract clients from the content of their experiences (Guttfreund, 1990; Ramos-Sánchez et al., 1999; Sciarra & Ponterotto, 1991; Torres et al., 2017). As well as

potentially misrepresenting their cognitions, clients using L2 may be denied the opportunity for emotional release, which can compound negative affect and hamper therapeutic progress (Sciarra & Ponterotto, 1991). Perez-Foster (1998) cautioned that “essential material” can be “lost in the cognitive traffic of bilingualism” (p.202) when therapy is not conducted in the client’s L1. Numerous studies have highlighted that when interventions are conducted in client/patient’s L2, the effort of focusing attention on translation can result emotions being tempered and/or ignored, making accurate assessments of their needs difficult (Novy et al., 2001; Snowden & McClellan, 2013; Softas-Nall et al., 2015; Torres et al., 2017; Van Loon et al., 2013; Woidneck et al., 2012). Misinterpretation by client and clinician due to language comprehension can lead to misdiagnoses and a failure to provide culturally competent, ethical care (Novy et al., 2001; Liu, 2013; Torres et al., 2017; Verdinelli & Biever, 2013).

English-monolingual therapists working with L2 English clients have reported feeling uncomfortable, inadequate and anxious regarding their communication effectiveness (Bowker and Richards, 2004; Stevens and Holland, 2008). However, even where therapists have learned a client’s L1, they have also reported discomfort and awareness of their lack of fluency and the impact this can have on the therapeutic process (Verdinelli & Biever, 2009). Therapists have highlighted that ensuring accurate translation of theoretical terminology and concepts can be challenging and distracting during therapy (Biever et al., 2002; Torres et al., 2017; Verdinelli & Biever, 2013). Bilingual practitioners have also reported finding it difficult to find the appropriate translation for clinical terms or phrases learned in English (Verdinelli & Biever, 2013). English has been found to be most therapists’ preferred language for practice because it is the language in which they trained (Altarriba & Santiago-Rivera, 1994). Psychological therapy training in English-speaking countries has been described as Anglo-centric and criticised for failing to prepare practitioners for working with speakers of other, often heritage, languages (Fondacaro & Harder, 2014; Minas et al., 1994; Wright, 2014).

1.4 Bilingualism & Mental Healthcare in Wales

Approximately 29% of the population of Wales speaks Welsh, a trend which appears to be on the increase despite marked regional variations e.g. 11% and 75% of the population in Fflint and Gwynedd respectively speak Welsh (Welsh Government [WG], 2019). Because of

bilingual education, most Welsh speakers are bilingual Welsh-English from school age, although English fluency can vary and many Welsh speakers consider themselves subordinate BP (Gathercole & Thomas, 2009; Madoc-Jones, 2004). When experiencing health-related difficulties, many L1 Welsh speakers have reported feeling more comfortable discussing such issues through the medium of Welsh (Misell, 2000; Madoc-Jones, 2004; Roberts et al., 2004; Williams, 2003). This reflects survey findings involving nearly 200 international bi/multilingual participants stating that the ability to express themselves in their language of choice during psychological therapy was highly valued (Dewaele & Costa, 2013). However, mental health (MH) services offered in Wales are largely English-medium only, as recruiting Welsh speakers into certain health professions is challenging (Thomas, 2005). Nonetheless, the lack of access to Welsh language MH services has been described as disadvantaging Welsh speaking patients (Madoc-Jones, 2004; Roberts et al., 2004). Patients have reported feeling ‘unreal’ and detached during English-medium psychological therapy; and that the lack of opportunity to speak Welsh had hindered their progress towards recovery (IAITH/WG, 2012).

2. RATIONALE

Although the literature is limited, provision of psychological therapy in clients’ preferred language has been found to be more effective overall and is clearly more inclusive and culturally sensitive. There is a commitment to increasing access to Welsh-medium psychological and MH services in Wales (WG, 2019). Clinical psychology programmes in Wales actively seek to recruit Welsh speaking clinical psychologists onto training programmes. Nonetheless, trainees and qualified clinical psychologists who can speak Welsh fluently are substantially underrepresented in the profession. It is hoped that this qualitative study into the experiences of bilingual Welsh-English clinical psychologists will provide some knowledge and insight that could inform services, training providers and practitioners.

3. THEORETICAL FRAMEWORK

This study aims to explore the experiences of first-language Welsh speaking clinical psychologists and to gain insight into what these have meant for them. It is therefore situated within an interpretive paradigm as it is concerned with understanding the world-view and subjective experiences of participants (Cohen, Manion & Morrison, 2007; Willis, 2007).

Consequently, research methodologies that are orientated towards capturing meaning and sense-making are the most appropriate for this qualitative study (Creswell, 2009). The study's qualitative, exploratory design will facilitate the examination of a phenomenon that has hitherto been unexamined: there has been no research to date examining the experience of Welsh first-language clinical psychologists. This design will enable the researcher to gather the rich detailed data required to answer the research question and address the identified gap in knowledge and understanding of how and what have been its participants' experiences. Interviewing participants with experience of the phenomenon under investigation facilitates exploration and capturing narrative related freely and without constraint.

Qualitative studies are inherently focused on words and language and language is at the core of this study. Language is a complex system of human communication which shapes world views and influences thought and experiences (Whorf, 1956). Reality and meaning is constructed through social interactions (Vygotsky, 1978). Powerful associations are formed between language and early memories, emotions and experiences (Pavlenko, 2012). From attachment with primary caregivers (Dubinsky & Bazhenova, 1997) to forming relational bonds and expressing needs, language is fundamental (Imberti, 2007; Costa, 2010). Language is an essential tool for expressing emotions and thoughts and in turn processing the meaning of these internalized experiences (Iannaco, 2009; Tehrani & Vaughan, 2009).

Bilingualism is generally and most simplistically defined as the ability to speak two languages with equal or near equal fluency (de Zulueta, 1990). However, proficiency in both languages varies as most bilingual people (BP) learn languages in different contexts and not always simultaneously (Castaño et al., 2007). Factors such as age, linguistic proficiency, the language's status, order and context within which language acquisition occurred can all impact upon a person's bilingualism (Presas, 2000). Not all BP become equally 'proficient' in both languages many BP are 'subordinate bilinguals' whose first language routinely dominates daily life and discourse (Irvin & Osgood, 1954; Sciarra & Ponterotto, 1991). Moreover, languages are not completely interchangeable and some words and concepts are beyond translation: even a fluent BP cannot always provide an exact translation of their internalised narrative (Scott, 2014). For many BP, their first language is viewed as their language of "emotional

expressiveness” (Burck, 2004, p.320) while their second language is associated with emotional distancing (Dewaele, 2004; Sutton et al., 2007). Amati-Mehler et al. (1991) purport that a child’s first language is also the medium by which he/she initially develops speech patterns and cognitive processes. Participants in this study will be bilingual and have experience of working as clinical psychologists, a profession in which language is a fundamental ‘tool’.

4. RESEARCH QUESTION/AIM

The aim of this study is to capture detailed, qualitative data from participants who are bilingual Welsh-English clinical psychologists in order to answer the following question: *“How have Welsh speaking clinical psychologists experienced professional training and practice?”.* Analysis of the data could inform the practice and professional development of Welsh-speaking clinical psychologists by providing insights into how participants have experienced training and working to address patients’ psychological difficulties. Findings may be of use and/or interest to practising clinical psychologists, service leaders and clinical psychology programmes seeking to increase the provision of Welsh-medium clinical psychological services.

5. STUDY DESIGN & METHODS (DATA COLLECTION & ANALYSIS)

5.1 Design

This small-scale, exploratory study is situated within an interpretive research paradigm and is qualitative and phenomenological in design. This research design is appropriate for gathering the rich, detailed descriptions required to answer the overarching research question of what have been participants’ experiences of working as bilingual Welsh-English clinical psychologists.

5.2 Data Collection

Data will be gathered in a single individual interview with each participant so that they can share their experiences and what these have meant for them openly and freely. Interviews will be largely unstructured so that participants can relate their experiences in their own words and without constraint. However, the researcher will have to hand a small number of questions to ensure the interviews stay on track and that key aspects are covered without overly restricting

participant responses. Unstructured interviews can reduce researcher influence on responses and minimize potential bias. However, they can also be challenging to manage with either verbose or reticent interviewees and require skilled interviewing.

Each interview will last no longer than 2 hours and most will probably take approximately 60 to 90 minutes. Time will be allowed before the start of each interview to build rapport and answer any questions participants may have regarding their involvement in the research. Before each interview commences, participants will be informed that they can take a break and/or terminate the interview at any time and be reminded of their right to withdraw. The purpose of the study as outlined in the bilingual Welsh and English briefing/information pack will be briefly reiterated but without engaging in a detailed discussion to minimize researcher influence on participants' responses. When the interview has concluded, each participant will be given a short debrief to provide a little more context on the study's purpose and an opportunity to ask any further questions. This debrief will also ensure that participants have an opportunity to raise any concerns they may have after reflecting on their experiences.

Participants will be invited to participate in the research interview which will take place at a time that suits them. Due to the uncertainty posed by the Covid-19 pandemic, interviews will take place over the phone or via video calls. To ensure confidentiality, the researcher and participant will each be located in a private room at a work or another convenient location. With participants' consent, each interview will be recorded using a small digital recorder supplied by NWCPP and transcribed as soon as possible afterwards. As well as ensuring all responses are captured, this avoids the potentially inhibiting effect of extensive note taking which can adversely impact researcher-participant rapport. However, transcripts will also be annotated with researcher's observations of paralinguistic communications e.g. laughter, pauses etc. made by participants during interviews. For that reason, recordings will be transcribed immediately. Transcripts and recordings will then be read and listened to simultaneously to check for accuracy and/or any omissions prior to analysis. Participant identities will be anonymised with the use of a pseudonym (P1, P2 etc) and the only biographical data collected, with the participant's consent, will be age and gender. The offer to conduct the interview in Welsh or English will be made to all participants. Interviews will

be transcribed verbatim and data analysed in the language of the interview although the written analysis and final empirical report/thesis will be written in English.

With participants' consent, all interviews will be recorded using a digital recorder provided by NWCPP. Recordings will be transferred onto an encrypted, password protected 'safe' USB memory stick as soon as possible after each interview. Recorded interviews will be transcribed verbatim onto password protected electronic documents. Any information that may identify participants e.g. names, locations etc will be removed to protect their anonymity. All participants will be assigned an anonymous reference (P and number) with the list of corresponding proper names and contact details stored securely in a locked cabinet accessible only to the researcher (see below for further details regarding data storage).

5.3 Analysis

Data will be analysed using the procedures for thematic analysis outlined by Braun & Clarke (2006) which provides a systematic, six-step process for analyzing qualitative data from in-depth immersion and familiarisation with the data through to generating initial codes, searching for, checking and defining themes. This six stage process, however, is flexible and iterative. Thematic analysis of qualitative data requires the researcher to cycle back and forth between each stage in order to rigorously re-examine emerging themes and ensure they reflect and capture the meaning of the text. After typing a transcript of each interview, the researcher intends to immerse in the data by listening to the recorded interviews a number of times to gain an overall sense of the data. Written transcripts will also be re-read for the same purpose, with any initial interpretations noted.

Following familiarisation with the data, colour coding will be used to highlight initial codes and themes with supporting text extracted from transcripts. Clusters of codes will then be categorized into emergent themes before these are then re-evaluated and labelled prior to writing up the analysis. It is hoped that this rigorous and systematic process will enable the researcher to present a credible analysis of the data. This is critical as subjectivity and bias can impact on the data and its analysis in qualitative research. To reduce the impact of subjectivity

and minimize the risk of bias, the researcher will regularly engage in reflective practice with the lead supervisor and keep a reflective journal throughout the research process.

Qualitative research which involves gathering detailed data via in-depth methods such as individual interviews typically involves small sample sizes, sometimes as small as 2-4 participants. The researcher believes that by aiming to have a sample of 6-8 participants, she will achieve data saturation at which point no further new themes will be present in the data.

6. STUDY SETTING

Data will be gathered using a single, individual interview with each participant. Due to the Covid-19 pandemic, interviews will be conducted either over the phone or via video call with both researcher and participant sitting in a quiet, private room. Research interviews will not take place in the workplace for health and safety reasons and to minimize impact on participants' work time when on clinical sites/offices. The interviews can be conducted anywhere as long as participants can be seated in private room that is quiet and free from interruptions so that they can speak freely and without constraint.

7. SAMPLE AND RECRUITMENT

Purposive sampling will be used to recruit participants for this study from among bilingual Welsh-English Clinical Psychologists working in Wales. To increase the dependability of this study and ensure participant confidentiality, participants will be recruited from across all health boards in Wales. The aim is to recruit 6-8 participants for inclusion in this qualitative study which will seek to gather in-depth, detailed data and therefore a small sample of participants is appropriate.

Once ethical approval has been obtained, participant recruitment will begin with the assistance of the supervisor(s) and other clinical psychology colleagues to identify a pool of potential participants. A bilingual Welsh and English participant information briefing document will be sent to all potential recruits with a covering letter inviting them to participate in the study. This briefing will provide details on the aim of the study and explain that their participation will be anonymous, voluntary and inform them of participants' right to withdraw. How data will be

captured, stored and confidentially destroyed after the study's completion will also be explained.

Potential participants will be able to indicate their interest by replying to the email which will also enclose a copy of the information briefing as an attachment. They will also be given contact details for the researcher should they wish to ask further questions prior to deciding whether to participate. If 8-9 participants express interest, the recruitment will close temporarily to avoid inconvenience to colleagues and having to reject potential recruits when attrition rates might necessitate a second round of recruitment. Provided all participants are qualified and practising clinical psychologists who identify as Welsh-English bilingual, no other exclusion criteria will be applied. All participants will be individually briefed prior to providing their signed, informed consent in a bilingual Welsh and English participant consent form and before any arrangements are made to gather data.

8. ETHICAL AND REGULATORY CONSIDERATION

This study will comply with data protection legislation and be guided throughout by Bangor University, BCUHB and BPS ethical codes of practice on research using human subjects. Ethical approval will be sought from the health board's R&D department and the School of Psychology. However, as participants will be members of staff and not patients, the researcher understands that there will be no need to apply for ethical approval from the NHS Research Ethics Committee.

As the research will involve reflecting on professional practice and personal narratives that have a strong experiential dimension, sharing these experiences during a one-to-one interview can be intense and trigger strong, potentially distressing emotions. Participants will be briefed on the potential risks of participating in research and reminded of their right to withdraw from the study. In the unlikely event that a participant should become distressed during the interview, the researcher will stop interviewing. The participant will be offered a short break or for the interview to be terminated and rearranged, unless they choose to withdraw completely. In such instances, participants will also be sign-posted to other appropriate sources of support if necessary. Although the researcher works therapeutically as a trainee clinical

psychologist, it will be made clear that her role in this study is as a researcher and the boundaries between these roles will be maintained throughout.

During the data-gathering stage, participants' will be reminded of their right to withdraw at any point during the research process up until the point where data analysis commences and reaches a stage where it may become problematic to extract their individual data. It will also be made clear that participation in the study is voluntary and that participant identities will be kept anonymous. All potential identifiers will be removed from data which will be stored securely to protect participants' anonymity. The limits of confidentiality will also be fully explained.

8.1 Risk Assessment

As the interviews will be seeking to capture personal experiences as practising bilingual; clinical psychologists, there may be a slight risk that this process may trigger difficult or distressing emotions for participants. This will be discussed with each participant before interviews commence, along with limits of confidentiality. If any participant does become distressed, the opportunity to explore this will be provided and a collaborative decision will be made regarding next steps, with the safety of the participant being paramount. If necessary, signposting and/or referral to appropriate support will be offered and any actions will be taken with the full consent of the participant. As interviews will take place via telephone or video calls with professional staff, risks to the researcher are minimal. Writing a reflective journal will enable the researcher to reflect on any personal issues that may arise as a result of carrying out the research and these will be discussed in supervision.

8.2 Data storage

This study will comply with the health board's confidentiality policy and data protection legislation at all times. All data will be securely stored throughout the duration of the project and confidentially destroyed once the study has been successfully completed. Audio files on the digital recorder will be deleted once successful transfer onto the encrypted memory stick has been verified. In the unlikely event that the digital recorder will need to be transported, a secure document holder will be used while the recorder is in transit. Electronically held data

will be stored in password protected files on a password protected computer stored in a locked cabinet accessible only to the researcher. Any paper notes, printed transcriptions and the encrypted safe-stick will also be stored in a locked cabinet and the key stored in a separate locked drawer. All participants will be allocated a P-number so that their identities remain anonymous. A list of participants' names and contact details will be known only to the researcher and this along with their contact details will be securely stored in a password protected file. Only the researcher and supervisors will have access to electronic and hard copies of other documents and data related to the project. On completion of this study, all paper data will be confidentially shredded and all electronic files deleted by the researcher in accordance with BCUHB procedures.

9. DISSEMINATION POLICY

Participants will be offered a summary of findings in the form of a brief document once the study has been completed. The researcher and supervisor also plan to disseminate findings to Clinical Psychology colleagues across BCUHB and health boards in Wales; and to Clinical Psychology Training Programmes in Wales. This will take the form of a poster, presentations and an academic journal article.

10. REFERENCES

(Removed due to word count limit and duplicated in Empirical Paper Reference List)

Word Count Statement

Thesis Abstract: 289

Section 1: Literature Review

Word count without references: 7040 (inc. abstract)

Word count with references: 9416

Tables and figures: 1209

Section 2: Empirical Paper

Word count without references: 9012 (inc. abstract)

Word count with references: 11,195

Footnotes, tables and figures: 38

Section 3: Contributions to Theory and Clinical Practice

Word count without references: 3794

Word count with references: 4960

Tables and figures: 21

Appendices

Word count: 10,952

Total:

Total word count excluding tables, figures, reference lists and appendices: 19,846

Total word count including tables, figures, references and appendices: 37,791

Overall thesis word count: 38,723